

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 3. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 28976		
1- STATE REGISTRAR		1. DECEASED NAME FIRST MIDDLE LAST						2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH DAY YEAR	2b. HOUR		
		Sarah R. Albins						<input checked="" type="checkbox"/> 11 13 1980				M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR	2d. HOUR
Female		White		Nov 13 1980		0 yrs.		MONTHS DAYS	HOURS MIN.	11 13 1980			4:40 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Md		USA										Harford County		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Harve de Grace		Harford Memorial Hospital						None						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS						
Md		Harford		Aberdeen		YES <input type="checkbox"/>		186 Farm Rd						
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST				
Richard		C.		Albins		Joy				Miller				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.						17. INFORMANT		ADDRESS				
No		N/A						Richard C. Albins		Same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fetal Distress Syndrome</b> Conditions if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b).														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?						
								<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE		TITLE (SPECIFY) <i>Margarita Korell</i> Assistant M.D.						MEDICAL EXAMINER			DATE SIGNED 11-14-80			
EXAMINER'S NAME (TYPE OR PRINT)		111 Penn Street												
ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		CITY, COUNTY, STATE						
Cremation		14 Nov 80		Loudon Park Crematory		Baltimore,		City, Maryland						
24. FUNERAL DIRECTOR NAME		ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Mitchell Funeral Home		Havre de Grace, Md.						NOV 17 1980		<i>Linda McPherson</i>				
BP														
DHMH-17 (VR A15 ME (5)) 15M 2/80														

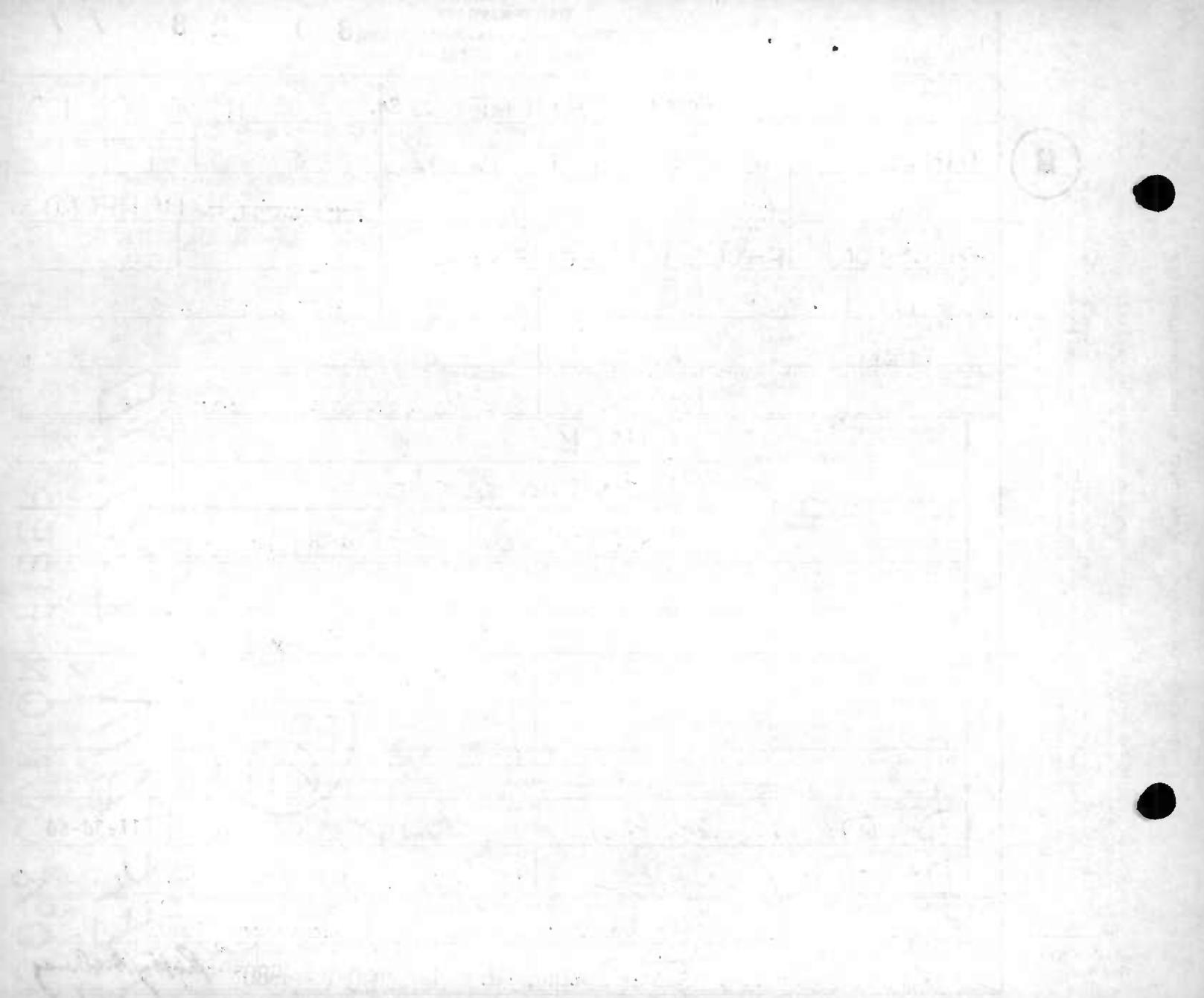


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, this medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	0	2	8	9	7
												REG. NO.					
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
			THOMAS Henry			ANDREW S.			11 30 80						1 A M		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE			WHITE			1 16 12			68			MONTHS	DAYS	HOURS	MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			FALLSTON HARFORD MD					
New York			USA														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
FALLSTON			FALLSTON GENERAL			Manager			IBM								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
Maryland			Harford			Aberdeen			YES <input type="checkbox"/> NO <input type="checkbox"/>			1313 Loflin Road					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
Walter Andrews			Unknown														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT wife			ADDRESS								
No			219-07-5968			Dorothy C. Andrews			same as 13								
18. CAUSE OF DEATH (Enter only one cause per line for all three parts)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK																	
1519 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinomatosis</i>					
												DUE TO, OR AS A CONSEQUENCE OF (c) <i>CANCER OF STOMACH</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from 10/28/80, 1980, to 1980, that (I) (we) last saw the deceased alive on 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 11-30-80					
22b. SIGNATURE <i>Bantun, Monakil</i>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BANTUN, MONAKIL</i>			22e. ADDRESS <i>Fallston Gen Hosp. Fallston, Md.</i>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 3, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery			23d. LOCATION CITY OR TOWN Rockville			COUNTY Mont.	STATE Md.				
24. FUNERAL DIRECTOR NAME Francis J. Collins 500 University Blvd., W. Silver Spring, Md.						25a. DATE REC'D. BY REGISTRAR DEC 1 1980			25b. REGISTRAR'S SIGNATURE <i>Ricky Kennedy</i>								



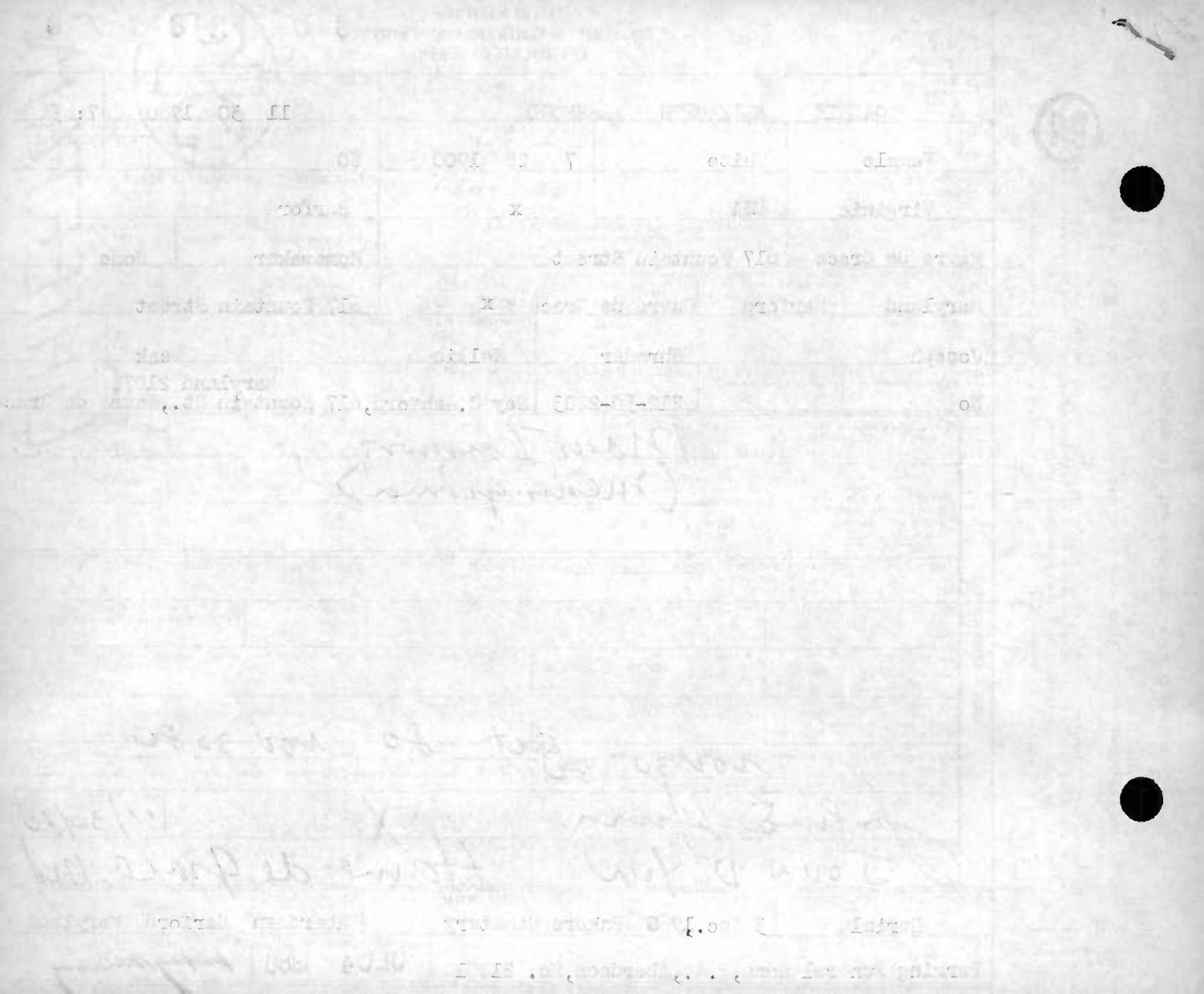
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director it should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80	28978				
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
CALLIE ELIZABETH ASHFORD						11 30			1980			7:15A M			
3. SEX <b>Female</b>			4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>7 28 1900</b>			6 AGE (IN YEARS LAST BIRTHDAY) <b>80</b>			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>			7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b>			MD.				
10 CITY OR TOWN OF DEATH <b>Havre de Grace</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>617 Fountain Street</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>							
13a STATE <b>Maryland</b>		13b COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Havre de Grace</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>617 Fountain Street</b>							
14. FATHER'S NAME FIRST <b>Joseph</b>			MIDDLE <b>Shrader</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Nellie</b>			LAST <b>Peak</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>212-50-2203</b>		17. INFORMANT <b>Ray C. Ashford, 617 Fountain St., Havre de Grace</b>			ADDRESS <b>Maryland 21078</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain Tumor</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>2252</b> (meningioma)															
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 30 1980</b> to <b>Nov. 30 1980</b> , that (I) (we) last saw the deceased alive on <b>Nov 30 1980</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <b>John D. Yun</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>11/30/80</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John D. Yun</b>			22e. ADDRESS <b>Havre de Grace, Md.</b>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3 Dec. 1980</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Bakers Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Aberdeen</b>			COUNTY <b>Harford</b>			
24. FUNERAL DIRECTOR NAME <b>Tarring Funeral Home, P.A., Aberdeen, Md. 21001</b>			ADDRESS			25a. DATE REC'D. BY REGISTRAR <b>DEC 4 1980</b>			25b. REGISTRAR'S SIGNATURE <b>Sophy McCloud</b>						



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 80 28979		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR		
William					Henry Ashworth	<input type="checkbox"/> 11 28 80			PM					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR		
M	W	2 5 24	56 yrs.			<input type="checkbox"/> 11 28 80			PM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford									
Va	USA													
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY			
Havre de Grace	HARFORD Memorial					MECHANIC					AUTO REPAIR			
USUAL RESIDENCE (IF IN HOSPITAL HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			12b. KIND OF BUSINESS OR INDUSTRY					
VA	South Hill	MECKLENBURG	YES <input checked="" type="checkbox"/>			203 BRYAN ST.								
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST							
JRA	W.	ASHWORTH	INEZ											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			ADDRESS									
YES	227-40-5326	Hospital Records												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) Coronary Heart Disease														
4149 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												DATE SIGNED 11-25-80		
ACTUAL SIGNATURE <u>Luis E. Renfro</u> M.D. Deputy MEDICAL EXAMINER														
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 464 Avenue R Havre de Grace											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 26 Nov 80			23c. NAME OF CEMETERY OR CREMATORIAL CRESTVIEW MEMORIAL PARK			23d. LOCATION CITY OR TOWN SOUTH HILL MECKLENBURG, VA			COUNTY	STATE	
24. FUNERAL DIRECTOR NAME			ADDRESS			25. INTESTATE BY PERTICULAR			26. SIGNATURE					
R. Madison Mitchell, HAVRE DE GRACE MD.						8000								

1780

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1. RETAIN PAGE 5 FOR YOUR PERSONAL USE. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 28980
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR		
Elva			Roach	Bachman	<input checked="" type="checkbox"/>	11	17	19	80	M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR		
female	white	Aug. 18, 1905	75 yrs.			11	17	19	80	12:30	PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA					Harford County					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Kingsville			Route #1 at Balt/Harford Line					Homemaker			--	
13a. STATE Maryland			13b. COUNTY Harford	13c. CITY OR TOWN Benson		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1809 Harford Road				
14. FATHER'S NAME FIRST John			MIDDLE A.	LAST Roach	15. MOTHER'S MAIDEN NAME FIRST Margaret		MIDDLE --	LAST Stephens				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 219-16-5267			17. INFORMANT Mrs. Margaret Sullivan, Benson, Md.			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <b>Multiple Injuries</b> DUE TO, OR AS A CONSEQUENCE OF  8160 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.  (b) DUE TO, OR AS A CONSEQUENCE OF  (c)												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?				
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR AM/MONTH DAY YEAR 11:25AM 11/17 80			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of auto/rolled over/ejected/pinned						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway			21f. LOCATION STREET Rt#1 at Balt/Harford Line, Kingsville,			CITY OR TOWN COUNTY STATE Harford County, MD			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE <i>Hormez R. Guard</i>												
TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER												
DATE SIGNED 11/17/80												
EXAMINER'S NAME (TYPE OR PRINT)			Hormez R. Guard, M.D.			ADDRESS 111 Penn Street, Balt., MD 21201						
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial			23b. DATE Nov. 20, 1980			23c. NAME OF CEMETERY OR CREMATORIAL St. John's Catholic			23d. LOCATION CITY OR TOWN Hydes			
									COUNTY Balto			
24. FUNERAL DIRECTOR NAME Howard K. McComas			ADDRESS 111, Abingdon, Md.			25a. DATE REC'D. BY REGISTRAR NOV 19 1980			25b. REGISTRAR'S SIGNATURE <i>Howard K. McComas</i>			
BP _____												
DHMH-17 (VRA15 ME(5))												
15M2/80												

Brachinibarbatus before now so much in the  
same place  
as follows, and the following is true.

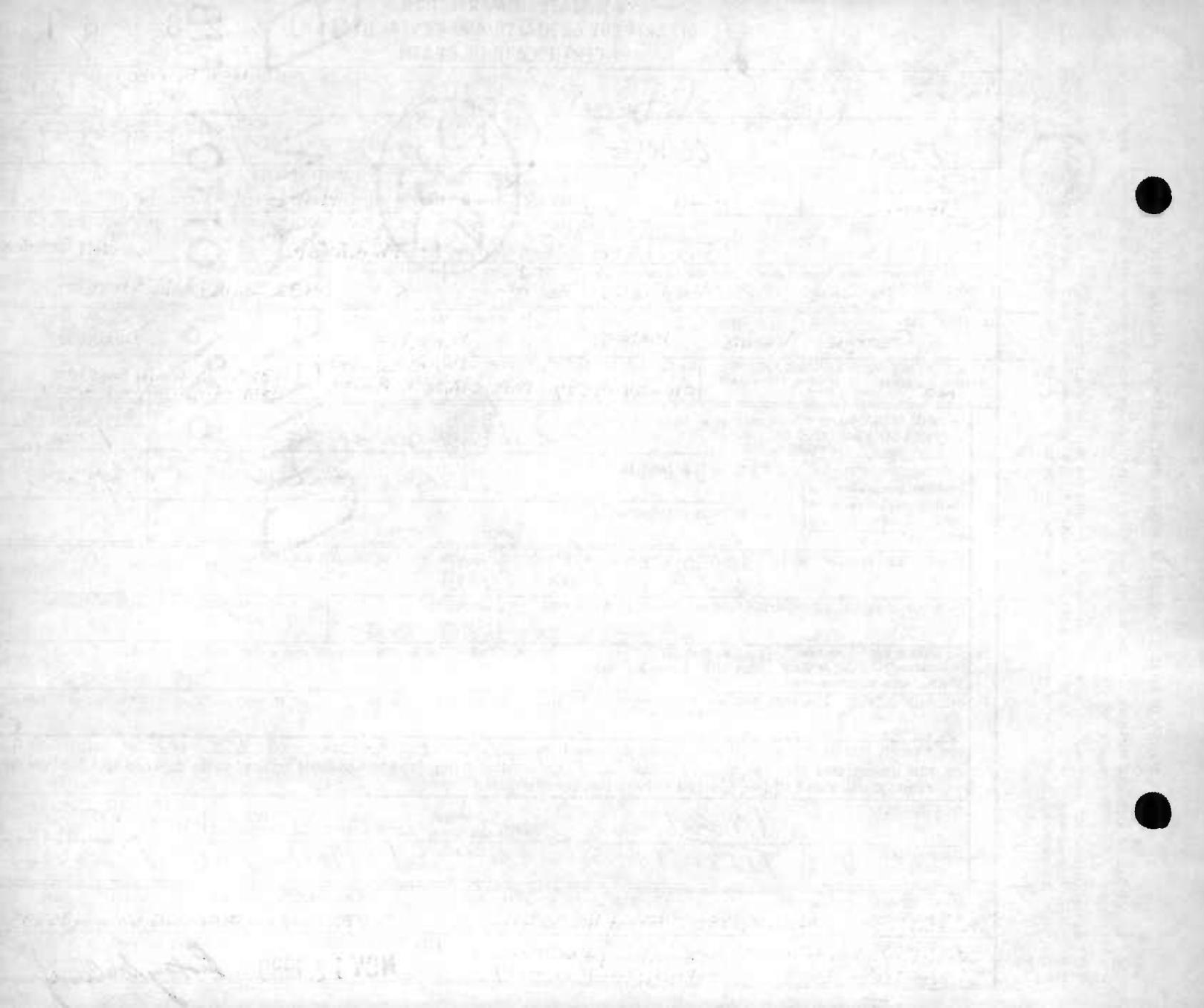
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

-10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 24 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH04-28981  
04-33-37

1. DECEASED-NAME (Type or print)	First <i>Paul</i>	Middle <i>Dobson</i>	Last <i>Bales</i>	2a. DATE OF DEATH (Month Day Year) Nov. 8, 1980	2b. HOUR 12 noon	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>2/25/02</i>		6. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Greenville, Tenn.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Hanford County</i>			
10. CITY OR TOWN OF DEATH <i>Fallston</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Fallston General</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Physician</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Civil Service</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Hanford Co.</i>	13c. CITY OR TOWN <i>Bethel</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>432 South Main Street</i>		
14. FATHER'S NAME First <i>GEORGE</i>	Middle <i>LEWIS</i>	Last <i>BATES</i>	15. MOTHER'S MAIDEN NAME First <i>MERTIE</i>	Middle <i></i>	Last <i>DOBSON</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>010-24-9577</i>	17. INFORMANT (WIFE) <i>Mrs. Olivia P. Bales</i>	Address <i>432 South Main Street Bethel, Maryland 21014</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Months years.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>End stage renal failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Pure BSC.N.D.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>-</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>EVA, liver cirrhosis.</i>						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
MEDICAL CERTIFICATION						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>10-17, 1980, to 11-8, 1980</i> , that (I) (we) last saw the deceased alive on <i>11-8, 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.						
22b. SIGNATURE <i>Paul</i>	DEGREE <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	ATTENDING PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>11-8-1980</i>			
22d. PHYSICIAN'S NAME (Type) <i>V.S. NAIR M.D.</i>	22e. ADDRESS <i>1716 Hanford Road 41</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Nov. 11, 1980</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Forest Hill Cemetery</i>	23d. LOCATION (City or Town) <i>Birmingham, Jefferson County, Alabama</i>	(County) <i>Jefferson County, Alabama</i>	(State) <i>35233</i>	
24. FUNERAL DIRECTOR <i>JOSEPH William FESTER</i>	ADDRESS <i>W. Broadway &amp; Williams St., Bethel, Maryland 21014</i>	25a. REC'D BY REGISTRAR <i>NOV 12 1980</i>		25b. REGISTRAR'S SIGNATURE <i>John Belcher</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						80 28982					
1 - STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)		ANNA ELIZABETH BARONELLA		2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Anna Elizabeth Baronella				11	4	80		13 12 P.M.			
3. SEX		4 RACE		5 DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Female		White		MONTH	DAY	YEAR	64				
7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		HARFORD COUNTY MD.	
Md. FALESTON		U.S.A.		12 29 15				Harford			
10 CITY OF BIRTH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Faleston		Faleston General Hosp.		HOMEMAKER							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
MD.		BALTO.		KINGSVILLE		13e. STREET ADDRESS 11206 CEDAR LANE					
14 FATHER'S NAME FIRST CLARENCE		MIDDLE BOOTH		LAST		15 MOTHER'S MAIDEN NAME ELIZABETH		MIDDLE		LAST GREIB	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-50-0540		17 INFORMANT LOUIS BARONELLA (HUSBAND)		ADDRESS SAME ADDRESS					
18 CAUSE OF DEATH (Enter only one cause per line for 1a), 1b and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gram negative septicemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>end stage hepatic failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>COP + Staph septicemia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (the hospital) attended the deceased from 10-1-1980 to 11-1-1980, that (I) (we) last saw the deceased alive on 10-1-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <u>V. NAIR</u>		22c. DEGREE				22d. DATE SIGNED 11-5-80					
224. PHYSICIAN'S NAME (TYPE OR PRINT) V. NAIR		22e. ADDRESS APT 1C, 2 LATIMER CT BALTIMORE MD 21237									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11/7/80		23c. NAME OF CEMETERY OR CREMATORIAL OAK LAWN		23d. LOCATION CITY BALTO.		COUNTY		STATE MD.	
24. FUNERAL HOME NAME SCITIMUNEK FUNERAL HOME, INC.		ADDRESS 9705 Belair Rd. Baltimore, Md. 21236		25a. DATE REC'D. BY REGISTRAR NOV 7 1980		25b. REGISTRAR'S SIGNATURE Lisley McCready					

(01)

2000 DATUM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8028983	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Lewis J Blackburn						November 1, 1980						2 AM	
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male			White		Aug 28 1906		74			MONTHS		DAYS	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.			
Md.			U.S.A.				Harford						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Havre de Grace			Harford Memorial Hosp.			Driver			Taxi				
13. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
Md.			Cecil		North East		YES <input checked="" type="checkbox"/>		3 S. Main St				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
Lewis			C		blackburn	Lexia McLaughlin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			217-16-7732			Margaret E. Blackburn			North East Md				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 496°												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1ds	
DUE TO, OR AS A CONSEQUENCE OF (b) CD Influenza													
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Pulmonary Disease													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on			10-31, 1980, to 11-1, 1980										
			11-1, 1980										
22b. PHYSICIAN'S NAME (TYPE OR PRINT)			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11-1-80				
Irvin R. Wachsman													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 11-3-80			23c. NAME OF CEMETERY OR CREMATORIAL Asbury			23d. LOCATION CITY OR TOWN Perryville Cecil Md			STATE	
Burial													
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR NOV 6 1980			25b. REGISTRAR'S SIGNATURE Larry Melvin				
Paul P. Louch North East, Md.													



TO HOSPITAL OR ATTENDING PHYSICIAN

**TO A FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8028984									
										REG. NO.									
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Lillian MIDDLE Marcus LAST Bramble		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR								
<i>Lillian</i>		<i>M. Bramble</i>				<i>11 1980</i>		<i>11</i>	<i>19</i>	<i>80</i>	<i>4:25 PM</i>								
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		# UNDER 1 YEAR		# UNDER 24 HRS									
<i>Female</i>		<i>white</i>		<i>Sept. 17, 1906</i>		<i>74</i>		<i>MONTHS</i>		<i>DAYS</i>									
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.											
<i>Maryland</i>		<i>USA</i>				<i>Harfard</i>													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
<i>Fallston</i>		<i>Fallston General</i>		<i>Billing Clerk</i>		<i>Dept. Store</i>													
13a. STATE Maryland										13b. COUNTY Harford		13c. CITY OR TOWN Joppatown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 532 "A" Rivera Dr.		Joppatowne, Md. 21085	
14. FATHER'S NAME FIRST Howard MIDDLE T. LAST Marcus										15. MOTHER'S MAIDEN NAME Margaret		16. ADDRESS 410 Nollmeyer Road Baltimore, Md. 21220							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO No -		17. INFORMANT William F. Bramble		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ankylosing</i>  5609 DUE TO OR AS A CONSEQUENCE OF (b) <i>Kerel Kailene</i>  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  DUE TO OR AS A CONSEQUENCE OF (c) _____																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Asev. MT</i>																			
19a. DATE OF OPERATION <i>10/8/80</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Small Bowel Obstruction</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____															
22a. I certify that (I) (the hospital) attended the deceased from <i>4 AM</i> , 19 <i>80</i> , to <i>8 PM</i> , 19 <i>80</i> , that (I) (we) lost sow the deceased alive on <i>5 Nov</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) did/did not view the body after death.										22c. DATE SIGNED <i>19 Nov 80</i>									
22b. SIGNATURE <i>Howard</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>															
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Howard</i>		22e. ADDRESS <i>FOX</i>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>11-22-80</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Elkton Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Elkton, Cecil Co., Maryland</i>		COUNTY		STATE									
24. FUNERAL DIRECTOR <i>Bruzdzinski Funeral Home PA</i>		ADDRESS <i>1407 Old Eastern Ave.</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 21 1980</i>		25b. REGISTRATION NO.													



1960 - 1961

1960-61

X

1960

X

1960-61

1960

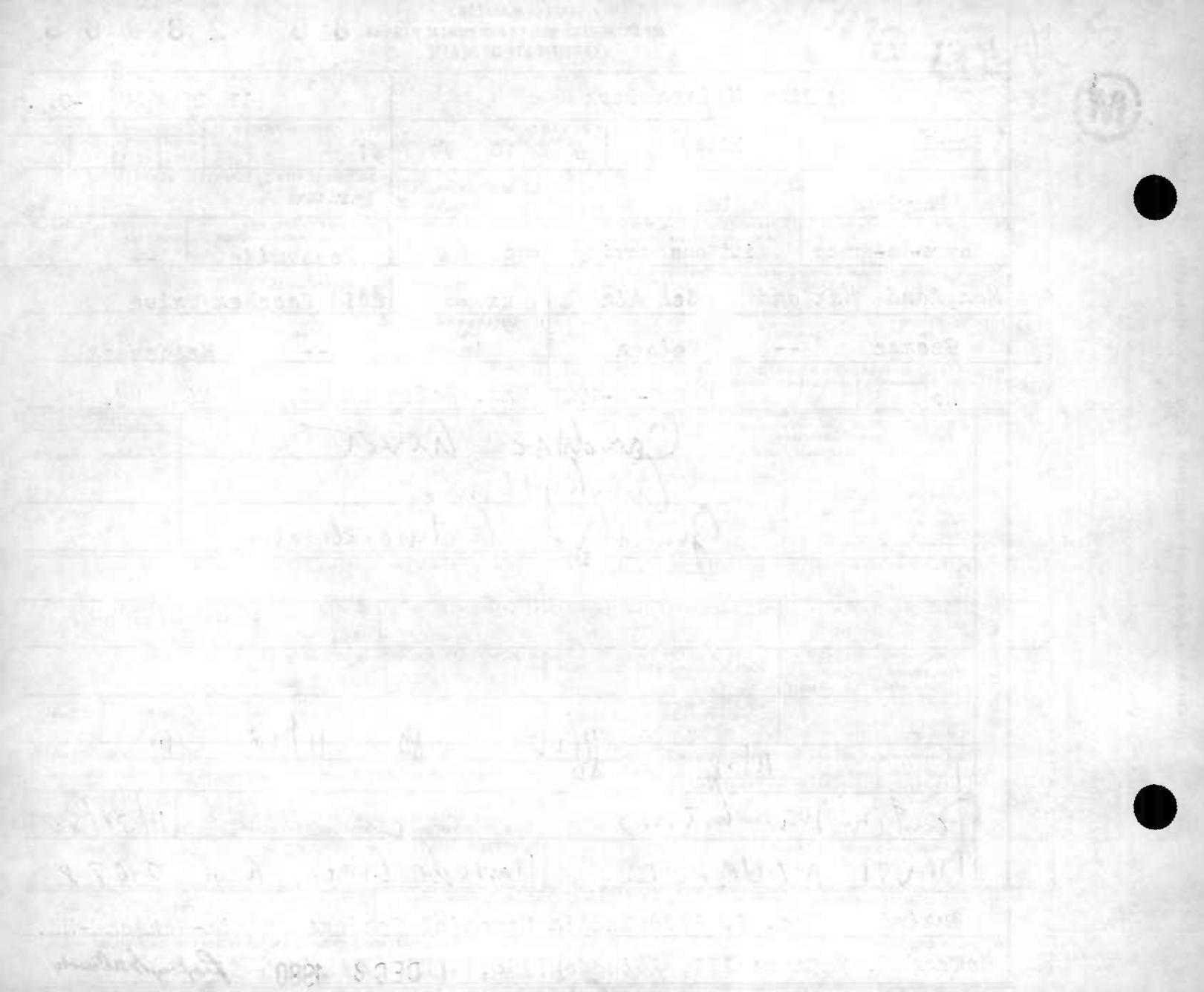
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					80 28985	
					REG. NO.	
1 - STATE REGISTRAR	1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST	2a DATE OF DEATH MONTH DAY YEAR	2b HOUR
	Lillian Neiser Burk				11 29 80	3-05 p.m.
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	# UNDER 24 HRS	
Female	White	6 10 99	81	MONTHS DAYS	HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	USA		Harford MD.			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Havre-De-Grace	Citizens Nursing Home			Housewife		
13 STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS		
Maryland	Harford	Bel Air		201A Crocker Drive		
14 FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
George -- Neiser	Anna -- Messenger					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS			
NO	220-22-1927	Mrs. Helen Krell, Bel Air, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arrhythmia</u> (c) <u>Grossly disorganized</u>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>11/28</u> 19 <u>80</u> , to <u>11/28</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11/28</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <u>Dante Monakil</u>	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 11/30/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS <u>Havre De Grace, Md 21078</u>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE Burial Dec. 2, 1980	23c NAME OF CEMETERY OR CREMATORIAL BelAir Memorial Gardens	23d. LOCATION CITY OR TOWN BelAir-Harford-Md.	COUNTY	STATE	
24 FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.	ADDRESS	25a. DATE REC'D. BY REGISTRAR DEC 2 1980	25b. REGISTRAR'S SIGNATURE <u>Lisley McComas</u>			

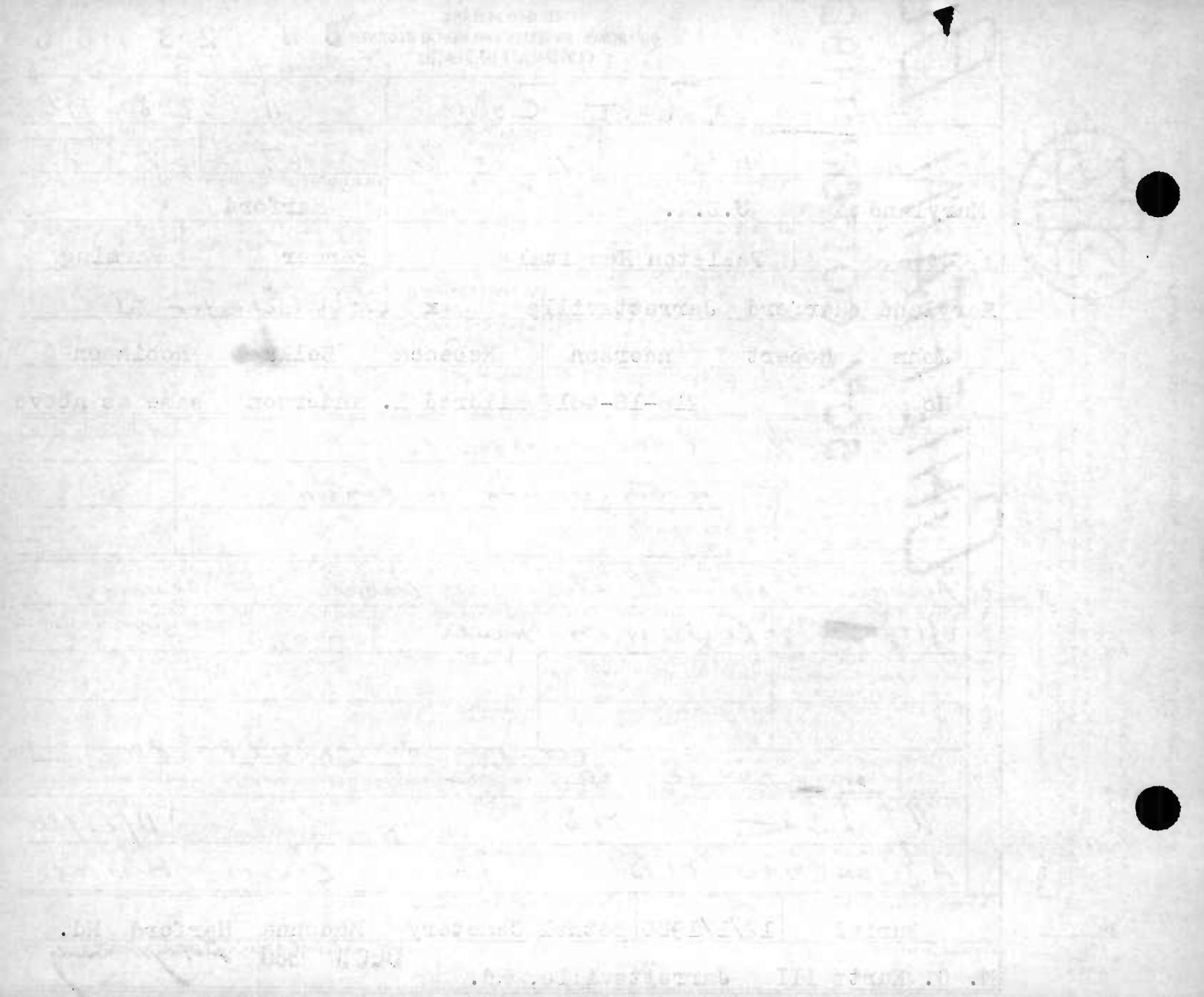


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8028986		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
<i>Anderson, Robert Calvin</i>						11 28 80						10 40 AM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male		White		MONTH DAY YEAR			67 YRS.			IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.		12 03 12			Harford					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Fallston		Fallston Hospital		Farmer			Farming					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Maryland		Harford		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2024 Schuster Rd					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
		John	Robert	Anderson				Rebecca	Belle	Robinson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS					
No		218-18-4812		Mildred E. Anderson			same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
1519 CARCINOMATOSIS												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Promoter carcinoma in stomach</i>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
<i>ALCOHOLISM, ASPIRATION PSEUDONITIS, CORVICAL SP.NG REACTUS</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
11/17/80		RESPIRATORY FAILURE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 30, 1980</u> , to <u>Nov 28, 1980</u> , that (I) (was not) saw the deceased alive on <u>Nov 28, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was not) (was not) view the body after death.												
22b. SIGNATURE		D.D.		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
A.J. Sweatman M.D.										11/28/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
A.J. SWEATMAN M.D.		Fulton General Hospital										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE		
Burial		12/1/1980		Bethel Cemetery			Madonna			Harford Md.		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REGISTRY			25b. RECORDED BY					
M. G. Kurtz III		Jarrettsville, Md.		DEC 3 1980								



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PRINT IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGE 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 8 9 8 7

1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>Billy</b>	MIDDLE <b>B.</b>	LAST <b>Campbell</b>	2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/>	MONTH 11	DAY 22	YEAR 1980	2b. HOUR M 11 22 1980 4:07 P.M.
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 14, 1934</b>	6. AGE (IN YEARS (LAST BIRTHDAY) <b>46 yrs.</b>	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD <b>11 22 1980</b>	MONTH DAY YEAR	2d. HOUR P 4:07 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Alabama</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford County, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Fallston</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fallston General Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Service Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Machinery</b>		
13a. STATE <b>Pennsylvania</b>	13b. COUNTY <b>York</b>	13c. CITY OR TOWN <b>Delta</b>		13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	13e. STREET ADDRESS <b>301 Chestnut Street</b>				
14. FATHER'S NAME FIRST <b>Lester</b>		MIDDLE	LAST <b>Campbell</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Lucy</b>		MIDDLE <b>M.</b>	LAST <b>Ellington</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Korean 422-40-6890</b>		17. INFORMANT <b>Stella M. Campbell, 301 Chestnut St., Delta, PA</b>		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  4292 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF  PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that I took charge of the remains described above, held on death resulted from: <b>Natural causes <input checked="" type="checkbox"/></b> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
TITLE (SPECIFY) <b>Assistant M.D.</b> MEDICAL EXAMINER									
ACTUAL SIGNATURE <i>Virginia L. Dolan</i>		DATE SIGNED <b>11/23/80</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>		ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 25, 1980</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Slate Ridge</b>		23d. LOCATION CITY OR TOWN <b>Delta</b>		COUNTY <b>York Co.</b>	STATE <b>Pennsylvania</b>
24. FUNERAL DIRECTOR NAME <b>John H. Harkins, 600 Main St., Delta, PA. 17314</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 26 1980</b>							

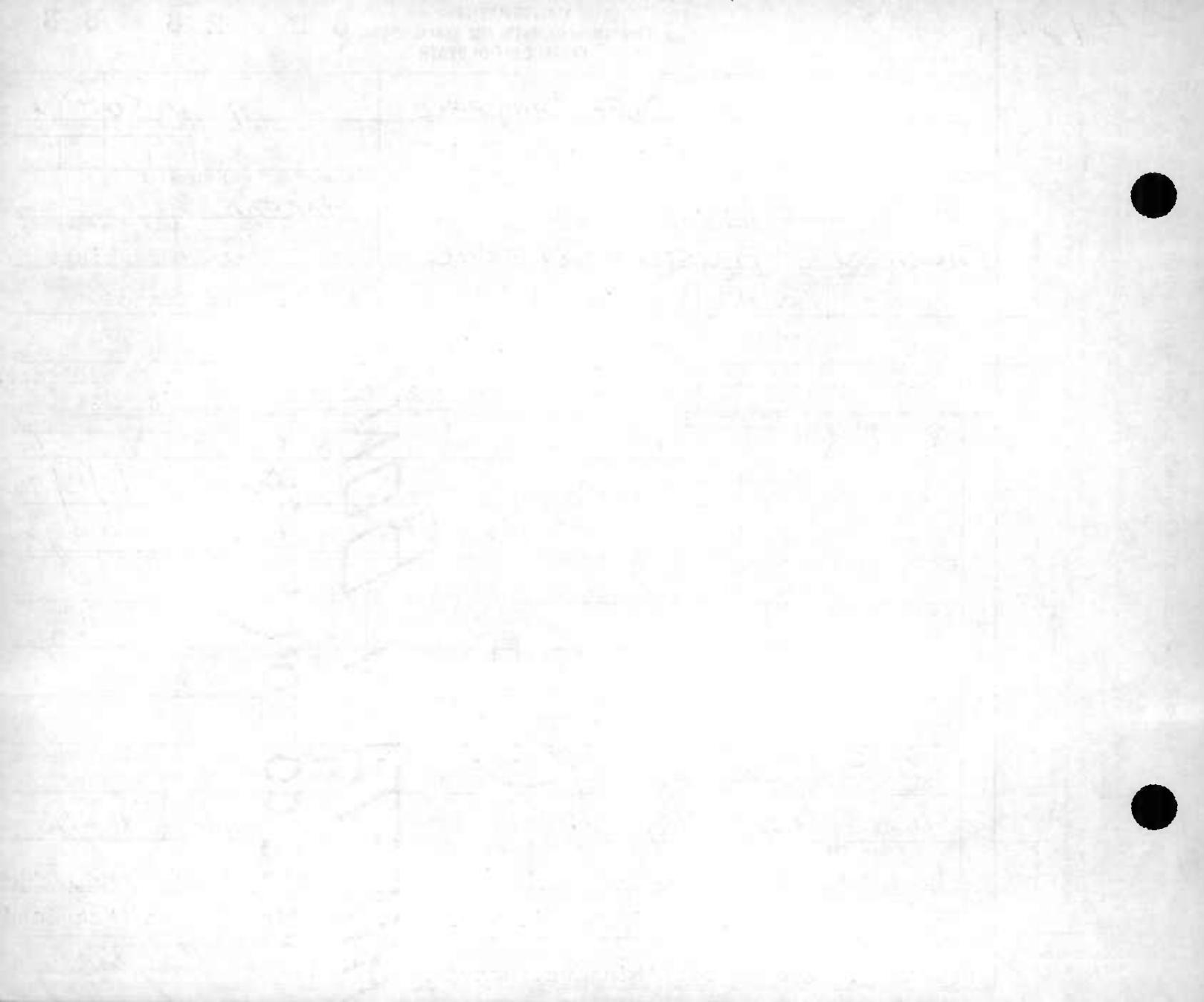
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, an other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 28488	
1 - FOR STATE REGISTRAR				2a DATE OF DEATH MONTH DAY YEAR								REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)				LAST				2b HOUR					
MILDRED DUFF CAMPBELL								4:30 AM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
Female		Caucasian		Sept. 8 1919		61		MONTHS DAYS		HOURS MIN			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		YRS.			
Maryland		U.S.A.						Harford					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
FALLSTON		FALLSTON GENERAL				Head Teller				Banking			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		MD.			
Maryland		Harford		Bel Air				108 S. Bond Street					
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME		R. MIDDLE		Hall					
Edward		Duff		Olive									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		108 S. Bond Street		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO		NONE		212-18-8790		Charles B. Campbell		Bel Air, Maryland					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asystole</i>													
4360 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last (b) <i>Cerebrovascular Accident</i> Native CVA - 10/18/80 DUE TO, OR AS A CONSEQUENCE OF (c) <i>Mitral Stenosis</i> CVA 6 Second year													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Mitral Stenosis and Atrial Fibrillation</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <i>9/2</i> , 1980, to <i>10/9</i> , 1980, that (I) (we) lost saw the deceased alive on <i>Never</i> , 19_____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>William Stratford May, M.D.</i>		22c. DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d. DATE SIGNED <i>11/9/80</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>William Stratford May</i>		22e. ADDRESS <i>Hilton Ave., Faquier General Hosp., Faquier</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Nov. 12, 1980		23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Mem. Gds.		23d. LOCATION CITY OR TOWN Bel Air Harford County Maryland State							
24 FUNERAL DIRECTOR NAME Howard K. McComas III Abingdon, Maryland		ADDRESS		25a. DATE REC'D. BY REGISTRAR NOV 12 1980		25b. REGISTRAR'S SIGNATURE <i>Henry Melody</i>							



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by a hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If hours 21 is recorded as less than 19 above, one of the following conditions must exist:

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 0 2 8 9 8 9

REG. NO.

1. DECEASED NAME [TYPE OR PRINT]			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
SAMUEL			CHESSOCK			11-20-1980.				8:00 PM	
3. SEX	MALE	4. RACE	WHITE	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
				6 5/03						IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?	USA	MARRIED	NEVER MARRIED	WIDOWED	DIVORCED	77 yrs.		MONTHS	YEARS
10. CITY OR TOWN OF DEATH	Havre de Grace, Md	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)	CITI-GEN'S NURSING HOME	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE	Maryland	13b. COUNTY	Harford	13c. CITY OR TOWN	Aberdeen	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS	Operating Eng'r U.S. Gov't			
14. FATHER'S NAME	Michael	FIRST	MIDDLE	LAST	Chessock	15. MOTHER'S MAIDEN NAME	Anna	FIRST	MIDDLE	LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	16b. SOCIAL SECURITY NO.	162-09-5335	17. INFORMANT	ADDRESS						
Michael Chessock, 728 Clayton St., Aberdeen, Md							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for 18, 1b, and 1c) PART I. DEATH WAS CAUSED BY							3 yr.				
IMMEDIATE CAUSE (a) 3312 Senile Dementia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							3 yr.				
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Generalized arteriosclerosis		19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
19c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. Verify that (I) (this hospital) attended the deceased from 9-1-1980, to 11-20-1980, that (II) (we) lost saw the deceased alive on 9-1-1980, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.											
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/>			MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			Lopez Sullivan			11-21-80			
Peter P. Rodman M.D.		8 Low St. Aberdeen Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		25a. REC'D.	25b. REC'D. FOR		
Removal/Burial		22 Nov. 1980		St. Peter & Paul Greek		Lopez Sullivan Pa.		NOV 25 1980	RECORDED		
24. FUNERAL DIRECTOR NAME		ADDRESS									
Tarring Funeral Home, P.A., Aberdeen, Md. 21001											

1900 GALLON CISTERNS

1900 GALLON CISTERNS

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1900 GALLON CISTERNS

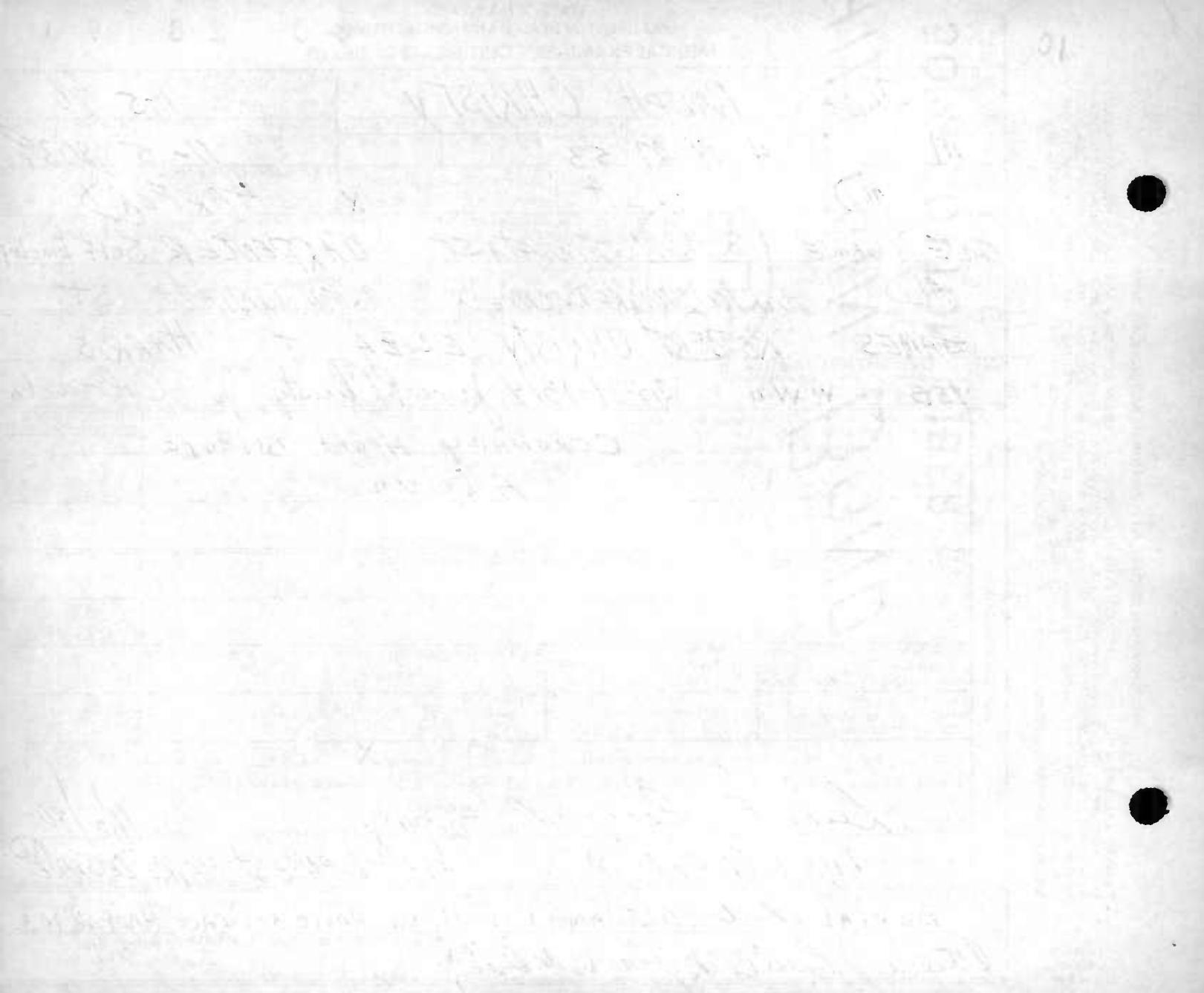
1900 GALLON CISTERNS

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 5. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 28990											
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR 11-5 1980				2b. HOUR 12 H											
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 4 18 27			6. AGE (IN YEARS) LAST BIRTHDAY 53 YRS.			IF UNDER 1 YR. <input type="checkbox"/> MONTHS		IF UNDER 24 HRS. <input type="checkbox"/> DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11-5 1980				2d. HOUR 12 H					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED X				9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD											
10. CITY OR TOWN OF DEATH HARVE DE GRACE				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT A SUCH FACILITY, GIVE STREET ADDRESS) 825 N. Juliata				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER				12b. KIND OF BUSINESS OR INDUSTRY Self Employ											
13a. STATE MD				13b. COUNTY HARFORD				13c. CITY OR TOWN HARVE DE GRACE				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 825 N. Juliata ST.									
14. FATHER'S NAME FIRST JAMES				MIDDLE ROBERT CHRISTY				LAST ELIZA J				15. MOTHER'S MAIDEN NAME HARRIS											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. WW II				17. INFORMANT 215-34-1314 James R. Christy, Jr. - Colorado				ADDRESS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) 4149 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.  (b) DUE TO, OR AS A CONSEQUENCE OF  (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								2d. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Luis E. Rentel, M.D.				TITLE (SPECIFY) M.D. DEPUTY				MEDICAL EXAMINER				DATE SIGNED 11/5/80											
EXAMINER'S NAME (TYPE OR PRINT) Luis E. RENTEL, M.D.				ADDRESS 444 ALLIANCE ST. HARVE DE GRACE MD.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11-10-80				23c. NAME OF CEMETERY OR CREMATORY ST. JAMES UNITED CHURCH				23d. LOCATION CITY OR TOWN HARVE de Grace, HARFORD, MD.				COUNTY				STATE			
24. FUNERAL DIRECTOR N/A				ADDRESS				25a. DATE REC'D. BY REGISTRAR NOV 12 1980				25b. REGISTRAR'S SIGNATURE R. Christy McElroy											



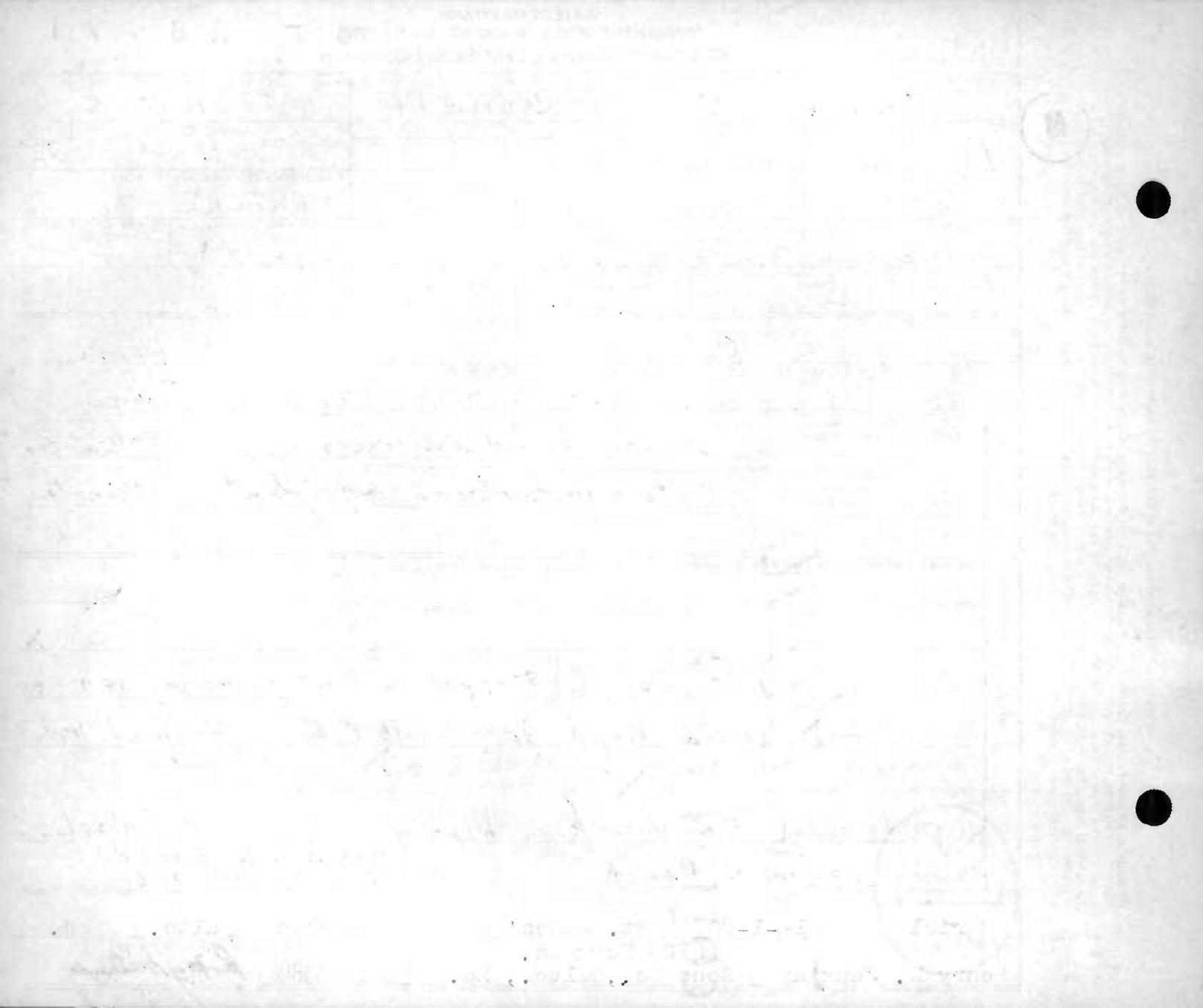
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

28991

REG. NO.

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
<b>GEORGE C. CLEMENT</b>						<input type="checkbox"/>	11	28	1980	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
M	W	FEB 4 16 64	64 yrs.			11	28	1980	245	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
MASS.		U.S.A.				HARFORD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
WHITEFORD		FAULSTON GEN. HOSPITAL			None			-		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS			
MD		BALTO.		MONKTON			TURNER Rd.			
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE		LAST		
George		R.		Clement	Alice			PEARL		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	ADDRESS					
YES		WWII		030-01-9035	LYDIA H. CLEMENT SAME					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <u>Severe head injuries</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>  Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>  (b) <u>auto - pedestrian accident</u> Minutes.  (c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:30 P.M. 11/28 1980			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  <u>Stepped in front of moving vehicle</u>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  <u>Rural Road</u>			21f. LOCATION STREET <u>Jarretsville Pike</u> CITY OR TOWN COUNTY <u>Harford, Md.</u> STATE					
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>			and in my opinion					
ACTUAL SIGNATURE <u>Samuel H. Henck</u>		M.D. <u>Deputy</u> MEDICAL EXAMINER			TITLE (SPECIFY) DATE SIGNED <u>11/28/80</u>					
EXAMINER'S NAME (TYPE OR PRINT) <u>Samuel H. Henck</u>		ADDRESS <u>721 Wheeler School Rd., Whiteford, Md. 21160</u>								
23a. BURIAL/CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-1-80		23c. NAME OF CEMETERY OR CREMATORIAL St. James'		23d. LOCATION CITY OR TOWN Monkton		COUNTY Balto.		STATE Md.
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co., Balto., Md.		ADDRESS 4905 York Rd.		25a. DATE REC'D. BY REGISTRAR DEC 2 1980		25b. REGISTRAR'S SIGNATURE <u>Riley McBrady</u>				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

See item 18-22 Film G 551 1/2/81 CP STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28992

FOR  
1 - STATE  
REGISTRAR,

1. DECEASED NAME (TYPE OR PRINT)			FIRST Edna	MIDDLE Louise	LAST Cromwell	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH 11	DAY 18 <sub>19</sub>	YEAR 80	2b. HOUR 14 HOUR Noon
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 3 - 5 - 1933	6. AGE (IN YEARS LAST BIRTHDAY) 47 yrs.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH 11	DAY 18 <sub>19</sub>	YEAR 80	14:00 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH Harford County, MD.
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10. CITY OR TOWN OF DEATH Fallston	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home
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13a. STATE Maryland	13b. COUNTY Harford	13c. CITY OR TOWN Edgewood	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 2141 Battle Street
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14. FATHER'S NAME FIRST Wallace	MIDDLE W.	LAST Govans	15. MOTHER'S MAIDEN NAME FIRST Laura	MIDDLE	LAST Blaney
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 219-30-4154	17. INFORMANT Robert L. Cromwell	ADDRESS Aberdeen, Md.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis</b> 4290 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
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21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
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22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
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ACTUAL SIGNATURE Virginia L. Dolan	TITLE (SPECIFY) M.D. Assistant	MEDICAL EXAMINER	DATE SIGNED 11/19/80
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EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.	ADDRESS 111 Penn Street
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/21/1980	23c. NAME OF CEMETERY OR CREMATORY Chestnut Grove	23d. LOCATION CITY OR TOWN Street	COUNTY Harford	STATE Md.
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24. FUNERAL DIRECTOR NAME M. G. Kurtz III	ADDRESS Jarrettsville, Md.	25a. DATE REC'D BY REGISTRAR NOV 24 1980	25b. REGISTRAR'S SIGNATURE
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 28993				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
MARY DORIS DEPASQUALE						11 24 80			11	24	80	6 A M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE		White		MONTH	DAY	YEAR	63			YEARS	MONTHS	DAYS	HOURS	MIN.
11 11 17		11 11 17			11 11 17			11 11 17			11 11 17			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH							
Baltimore, Md.		U. S. A.		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			Harford Co.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
FALLSTON		FALLSTON GENERAL		House wife			Home maker							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										Pylesville, Md.				
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Pylesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 4069 Heap School Rd. 21132					
14. FATHER'S NAME FIRST Harry		MIDDLE Smith		LAST		15. MOTHER'S MAIDEN NAME FIRST Mammie			LAST Connelly					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 217-84-6220		17. INFORMANT Mr. John J. DePasquale, 4069 Heap School Rd.			ADDRESS Pylesville, Md. 21132							
18. CAUSE OF DEATH (Enter only one cause per line for item 18, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Acute lancytopeneia 2030 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Multiple myeloma &				
										(c) Atrial fibrillation & Valvular Disease				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from Nov. 6th 1980 to Nov. 24th 1980, that (I) (we) last saw the deceased alive on Nov. 24th 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Nurli Mathur</i>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-24-80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nurli Mathur, MD		22e. ADDRESS 1305 Fairview Rd, Fallston, Md. 21047												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-26-1980		23c. NAME OF CEMETERY OR CREMATORIAL Belair Memorial Gardens Belair			23d. LOCATION CITY OR TOWN Harford		COUNTY	STATE Md.				
24. FUNERAL DIRECTOR NAME E.F. Lassahn, 11750 Belair Rd, Kingsville, Md. 21087		ADDRESS 11750 Belair Rd, Kingsville, Md. 21087		25a. DATE RECEIVED BY REGISTRAR NOV 28 1980			25b. RECEIVED BY SIGNATURE <i>E.F. Lassahn</i>							

PARISIENNE MOTOREN

PARISIENNE MOTOREN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 2 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												28994		
1. DECEASED NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR					
MARTHA			S.	DONOVAN		11	Month	3	Day	80	Year			
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH 1-30-1902			6. AGE (In years last birthday) 78					
7b. BIRTHPLACE (State or foreign country) 75 PAKISTAN			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. COUNTY OF DEATH HARFORD					
10. CITY OR TOWN OF DEATH 90 HAVRE DE GRACE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CITI'EN NURS.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORED			12b. KIND OF BUSINESS OR INDUSTRY AMER. CAR.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE 35 MD			13b. COUNTY HARFORD			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER MARKET & READING AVE 1104		
14. FATHER'S NAME First JACOB			Middle SHERICK	Lost	15. MOTHER'S MAIDEN NAME First MARGARET			Middle			Last SHERICK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown). 16b. SOCIAL SECURITY NO. 16c. INFORMANT 16d. ADDRESS			16a. (If yes give war or dates of service) no 16b. 215-09-X333 16c. HERBERT CHAMBERS 16d. STURBRIDGE									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7970 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF old age.														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nailly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I), (we) (did) (did not) view the body after death.												22c. DATE SIGNED 11-3-80		
22b. SIGNATURE Mezei Lajos			22d. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22e. ADDRESS 439 Girard St. Havre de Grace								
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL			23b. DATE 11-7-80			23c. NAME OF CEMETERY OR CREMATORIAL ST. STARISHAUS			23d. LOCATION (City or Town) BOSTON			(County) (State)		
24. FUNERAL DIRECTOR John M. McElroy & Sons CHESTER PT			ADDRESS 401 S			25a. REC'D BY REGISTRAR NOV 5 1980			25b. REC'D BY SIGNATURE John M. McElroy & Sons CHESTER PT					
OHMH-16 1/71 30M (VR A15 (4))														

1

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 24 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										28995	
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Daisy			U	Virginia	Dohsey	Month	Day	Year	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
3. SEX			4. RACE			5. DATE OF BIRTH			MONTHS DAYS HOURS MIN.		
Female			Black			4-3-1901			6. AGE (In years last birthday) YRS.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Hartford Co			U.S.A.						Hartford Co.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Home De Grace			Breckin N. Home			Housewife			Old Quaker Lane Rd.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Md.			Hartford			Baltimore					
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
William						Dohsey			Mary		Cochrane
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
(If yes give war or dates of service)			216-28-5861			J. Cecilia, RN			Bob Bain		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Pulm Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/>		NO <input type="checkbox"/>				YES <input type="checkbox"/>		NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>3/12</u> , 19 <u>80</u> , to <u>11/13</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>11/1/80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Dudley Phillips</u>		22c. DATE SIGNED <u>11/3/80</u>				DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <u>Dudley Phillips and</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>11-5-80</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Berkley</u>		23d. LOCATION (City or Town) <u>Darlington</u>		(County) <u>Hartford</u>		(State) <u>Md.</u>	
24. FUNERAL DIRECTOR <u>Beard Funeral Ser 117 Cecil Ave</u>		ADDRESS <u>North East, Md.</u>		25a. REC'D BY REGISTRAR <u>Nov 7 1980</u>		25b. REGISTRAR'S SIGNATURE <u>Barry McBrady</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 24 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

28996

1. DECEASED NAME (Type or print)				First	Middle	Last	2d. DATE OF DEATH Month	Day	Year	2b. HOUR 1130 AM
HERBERT				Homer		Fidler	10	19	80	
3. SEX: <b>MALE</b>		4. RACE: <b>White</b>		5. DATE OF BIRTH <b>6/17/17</b>		6. AGE (in years lost birthday) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7d. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>HARFORD</b>				
10. CITY OR TOWN OF DEATH <b>FALLSTON</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>FALLSTON GEN. Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>BALTIMORE CITY WATER Dept.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>CITY WATER</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>HARFORD</b>		13c. CITY OR TOWN <b>STREET</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>3309 Grier Nursery Rd.</b>		
14. FATHER'S NAME First <b>Charles</b>			Middle	Last	15. MOTHER'S MAIDEN NAME First <b>Mary</b>		Middle	Last <b>Bosley</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-18-3144</b>		17. INFORMANT <b>Mrs. Geneva L. Fidler</b>		Address <b>Street, Md. 21154</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>MYOCARDIAL INFARCTION</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CORONAR ARTERY DISEASE										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from <b>10-10 AM 11/19/1980</b> , to <b>11:30 AM 11/19/1980</b> , that (I) (we) last saw the deceased alive on <b>11/19 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) <b>not</b> view the body after death.										
22b. SIGNATURE <b>M. A. Thomas M.D.</b>		22c. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22d. PHYSICIAN'S NAME (Type) <b>M. A. THOMAS</b>		22e. ADDRESS <b>FALLSTON GEN. HOSPITAL 200 MILTON AVE. FALLSTON MD 21047</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/22/80</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Lake View Mem. Park</b>		23d. LOCATION (City or Town) <b>Sykesville</b>		(County)	(State) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>A. Alan Seitz, Jr. Funeral Home 3818 Roland Ave.</b>		ADDRESS		25a. RECD BY REGISTRAR <b>NOV 24 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Property of Maryland</b>				



SAFETY, SECURITY AND CIVIL LIBERTIES

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## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death - Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 24 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

28997

1. DECEASED-NAME (Type or print)	First <i>William</i>	Middle <i>Alfred</i>	Last <i>Gordon</i>	2a. DATE OF DEATH Month 11 Day 4 Year 80	2b. HOUR 10 30 A.M.
3. SEX <i>Male</i>	4. RACE <i>Black</i>	S. DATE OF BIRTH <i>4-2-00</i>	6. AGE (in years lost birthday) <i>80</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH <i>Harfond</i>		
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Brevin Nursing Home</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Custodian</i>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>	13b. COUNTY <i>Harfond</i>	13c. CITY OR TOWN <i>Havre de Grace</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>653 Pennington Ave.</i>	
14. FATHER'S NAME First <i>John</i>	Middle <i>-</i>	Last <i>Gordon</i>	15. MOTHER'S MAIDEN NAME First <i>Mary</i>	Middle <i>Emily</i>	Last <i>James</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16b. SOCIAL SECURITY NO. <i>214-22-5076</i>	17. INFORMANT <i>Henry L. Gordon - Aberdeen, Md.</i>	Address		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Self killing</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that, (I) (this hospital) attended the deceased from <i>9/3/80</i> , to <i>11/4/80</i> , that (I) (we) last saw the deceased alive on <i>11/3/80</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>John de Gruy Jr</i>	22c. DATE SIGNED <i>9/3/80</i>	22d. DEGREE ATTENDING PHYS.	22e. ADDRESS <i>Havre de Grace, Md.</i>	22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Nov. 8, 1980</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Berkeley Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Darlington Harford Md.</i>	25a. REC'D. BY REGISTRAR DATE <i>NOV 6 1980</i>	25b. REGISTRAR'S SIGNATURE <i>Henry McCreary</i>
24. FUNERAL DIRECTOR <i>Otis J. Bullock, Harford, Md.</i>	ADDRESS				

A-15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please return certificate papers, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 80 28998							
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR 1:57M p		
Thomas B. Grafton, Jr.					11/23/80						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Male		White		2 2 1898		82 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Maryland		USA				Harford, Co.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Havre De Grace		Citizens Nursing Home				Carpenter		Self Employed			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		2024 S. Fountain Green Road	
Maryland		Harford		Bel Air		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		ADDRESS		Bel Air, Maryland 21014	
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST	Eleanor Foy, 2024 S. Fountain Green Rd.			
T. Burlington		Grafton, Sr.		Mary		E.	Minnick				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.				17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		220-18-7019									
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY		IMMEDIATE CAUSE (1a)				Respiratory failure					
4292		DUE TO, OR AS A CONSEQUENCE OF (b) COPD									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Brian T. Grafton</i>		DEGREE <i>A.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/23/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 26 Nov. 80		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Tabor Methodist		23d. LOCATION CITY OR TOWN Bel Air Harford Maryland		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001		ADDRESS		25a. DATE REC'D. BY REGISTRAR NOV 26 1980		25b. REC'D. BY CLERK'S SIGNATURE <i>John St. John</i>					

6

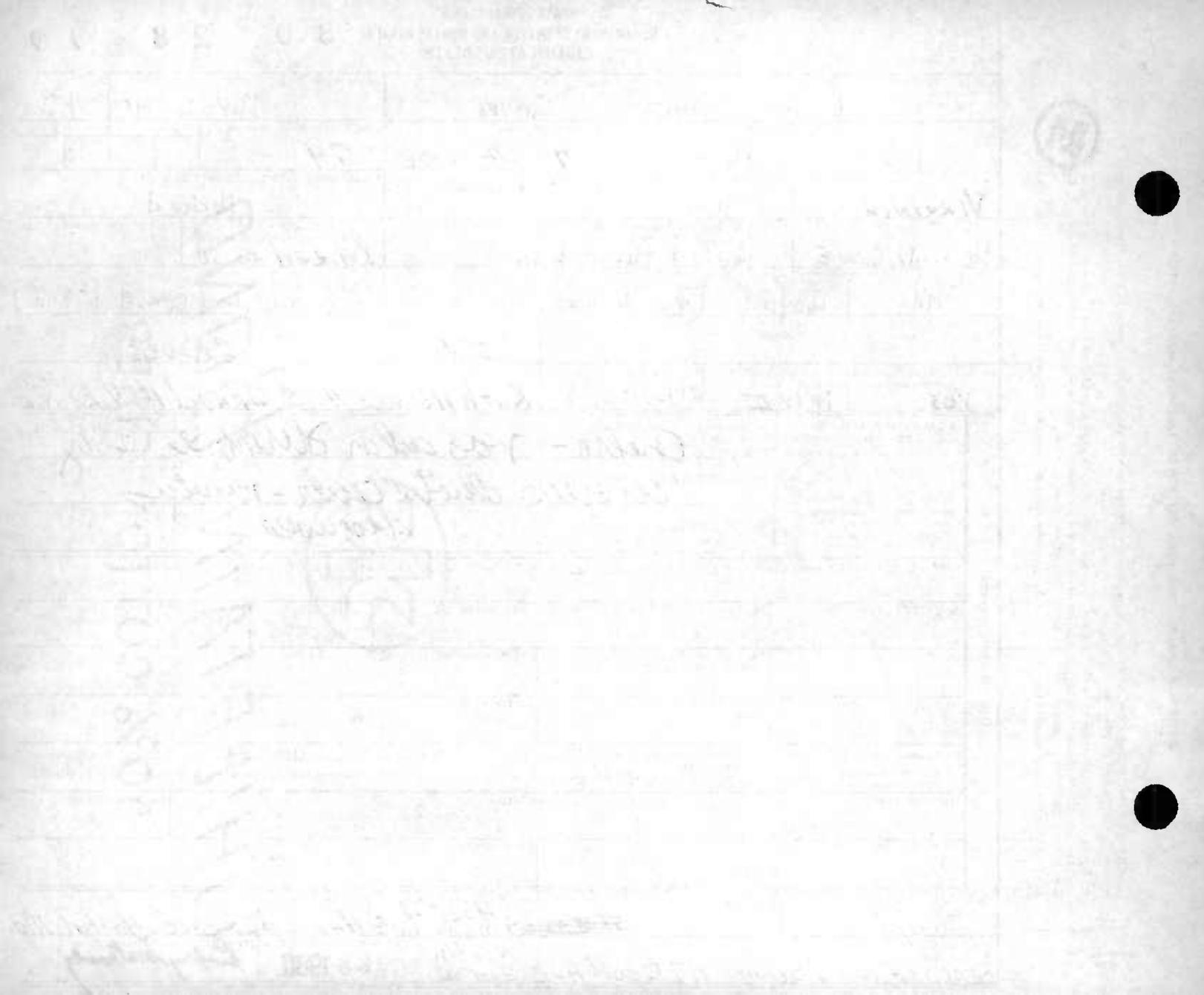
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8028999	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
ENNIS MUN GRAVES						Nov	20	1980				9:30 P.M.	
3. SEX			4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Male			Negro	MONTH	DAY	YEAR	74		IF UNDER 12 HRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8	Sep	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	MONTHS	DAYS	HOURS	
Virginia			USA							YRS.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SAME CITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Harford de Grace			Harford Memorial Hosp			Retired Mason							
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Md.			Harford						P.O. Box 132 (Gravel Hill Rd.)				
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			LAST					
					Ida			Geaves					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
Yes			WWII			Ruth Holmes 4115 Gravel Hill Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral - was born in Baltimore 2/29/4340</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic cerebral - vascular</i> { DUE TO, OR AS A CONSEQUENCE OF (c) <i>diseases</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from Nov 10, 1980, to Nov 20, 1980, that (I) (we) last saw the deceased alive on Nov 20, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <i>Irvin L. Wachsmann</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-22-80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS										
IRVIN L. WACHSMAN M.D.			HAUDE GRACE Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL SERVICES			23d. LOCATION CITY OR TOWN			COUNTY	STATE
Burial						Harford Memorial			Harford de Grace				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
BEARD'S Funeral Service 117 Cecil Ave			North East			NOV 28 1980			<i>Troy Melody</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign here.

REMAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						80 29000						
						REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
RUTH				Naomi	HACKETT	Nov - 18 - 1980				8:15 AM		
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)						
Female		Cauc.	MONTH	DAY	YEAR	81	YRS.	IF UNDER 1 YEAR	IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. X X X X X NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md		US			WIDOWED X DIVORCED		HARFORD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY		
Fallston		Fallston Gen. Hosp.			Housewife					--		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. INSIDE CITY LIMITS					13c. STREET ADDRESS	
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN JOPPA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					1700 MOUNTAIN RD -	
14. FATHER'S NAME FIRST John			MIDDLE Jessie	LAST Riley	15. MOTHER'S MAIDEN NAME FIRST Margaret			MIDDLE Agnes	LAST McCall	ADDRESS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO 219-28-7790			17. INFORMANT Mr. and Mrs. Franklin J. Hackett, Joppa, Md.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1097.			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u>  4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  (b) <u>CONGESTIVE</u>  (c) <u>ARTERY ANOMIA</u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <u>BILATERAL FEMORAL ARTERY OBSTRUCTION SECONDARY TO ARTERIAL THROMBOLYSIS</u>												
19a. DATE OF OPERATION 11/16/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BILATERAL FEMORAL ARTERY OBSTRUCTIONS			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Nov 16</u> , 19 <u>80</u> , to <u>Nov 18</u> , 19 <u>80</u> , that (1) <input checked="" type="checkbox"/> (s/he) saw the deceased alive on <u>Nov 18</u> , 19 <u>80</u> , and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (1) <input checked="" type="checkbox"/> (s/he) did <input checked="" type="checkbox"/> (did not) view the body after death.												
22b. SIGNATURE <u>A. Sauer</u>						22c. DEGREE M.D.						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SWARTZMAN</u>						22e. ADDRESS Prison Service Hosp						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov 21, 1980		23c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN Baltimore		23e. COUNTY		23f. STATE Md.		
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.						25a. DATE REC'D. BY REGISTRAR NOV 21 1980		25b. REPORTER'S SIGNATURE <u>Randy Bradley</u>				



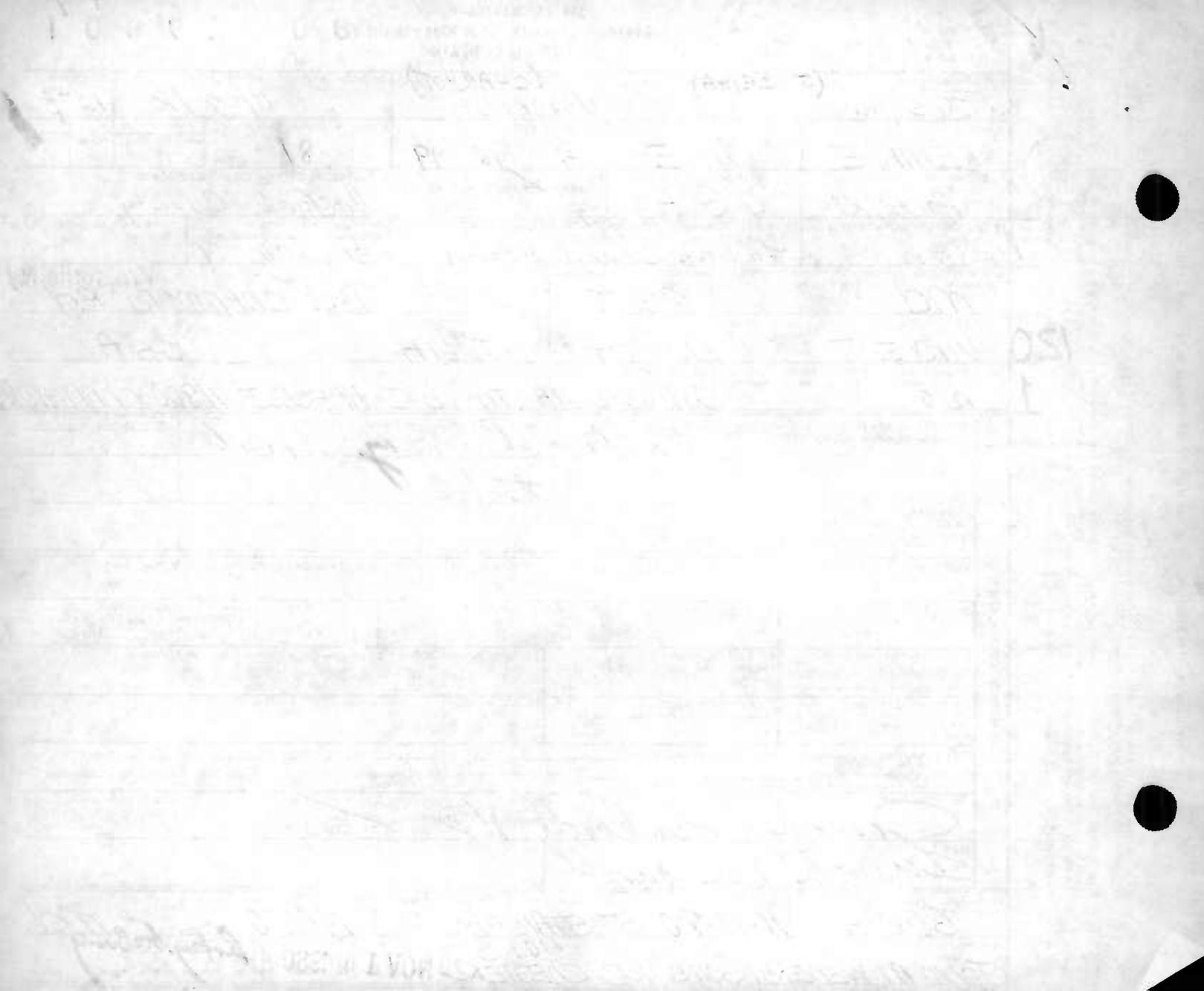
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 29001		
										REG. NO.		
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				LAST (CHARLOTTE) Harchut		2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 12 <sup>30</sup> P.M.	
		Josephine E.				4 15 99		11/2/80				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
FEMALE		WHITE		4 15 99								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD						
Poland		U.S.A.										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEWING MACHINE OP.			12b. KIND OF BUSINESS OR INDUSTRY Kingsville, Md					
Fallston		Fallston General Hospital										
13a. STATE Md		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14. STREET ADDRESS 11800 CHAPMAN Rd				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
VINCERIT		JULIA LUKSA										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> NO		16b. SOCIAL SECURITY NO 217-05-61678		17. INFORMANT JAKUB C HARCHUT		ADDRESS 11800 CHAPMAN		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4360 Cardiopulmonary Arrest												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Stroke												
DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____ 19 _____, to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we did/did not) view the body after death.												
22b. SIGNATURE Joseph Pankavich		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 11/11/80								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Pankavich		22f. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL 1. BURIAL		23b. DATE 11-11-80		23c. NAME OF CEMETERY OR CREMATORIAL ST STANISLAW		23d. LOCATION CITY OR TOWN Baltimore		COUNTY STATE				
24. FUNERAL DIRECTOR NAME John M. WEBER & Sons INC. CHESTER		ADDRESS NO. 13		25a. DATE REC'D. BY REGISTRAR NOV 10 1980		25b. DATE REC'D. BY REGISTRAR NOV 10 1980		25c. DATE REC'D. BY REGISTRAR NOV 10 1980				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80	29002			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH							REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	MONTH	DAY	YEAR	2b. HOUR					
Donald Francis Harkins						9	5	16	11 - 9 - 80					
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			White	MONTH	DAY	YEAR	64	YRS.	MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			U.S.A.						Harford					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Fallston			Fallston General.							Real Infy. Operator			Steel Fabrication	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Maryland			Harford Co.		Bel Air		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1011 Conowingo Road				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
Nelson F. V.					Harkins	Mary			L.		Skillman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT (Wife) 838-5370 ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
YES - Army			WW2			212-03-5945			Mrs. Pauline J. Harkins Bel Air, Maryland 21014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.  (b) DUE TO, OR AS A CONSEQUENCE OF MYOCARDIAL INFARCTION  (c) DUE TO, OR AS A CONSEQUENCE OF CORONARY ARTERIAL DISEASE.														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1 - 30 PM 11/9, 1980, to 3:30 PM 11/9, 1980, that (I) (we) last saw the deceased alive on 11/9 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE M. A. Thomas			DEGREE							22c. DATE SIGNED 11/9/1980				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. A. THOMAS M.D.			22e. ADDRESS FALLS ROW GEN. HOSPITAL FALLSTON MD 21047											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 12, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens			23d. LOCATION CITY OR TOWN Bel Air, Harford Co., Maryland 21014			COUNTY	STATE	
24. FUNERAL DIRECTOR Joseph William Foster Josephine Foster			ADDRESS W.Broadway & Williams St. Bel Air, Maryland 21014			25a. DATE REC'D. BY REGISTRAR NOV 12 1980			25b. REGISTRAR'S SIGNATURE Patricia L. Brown					

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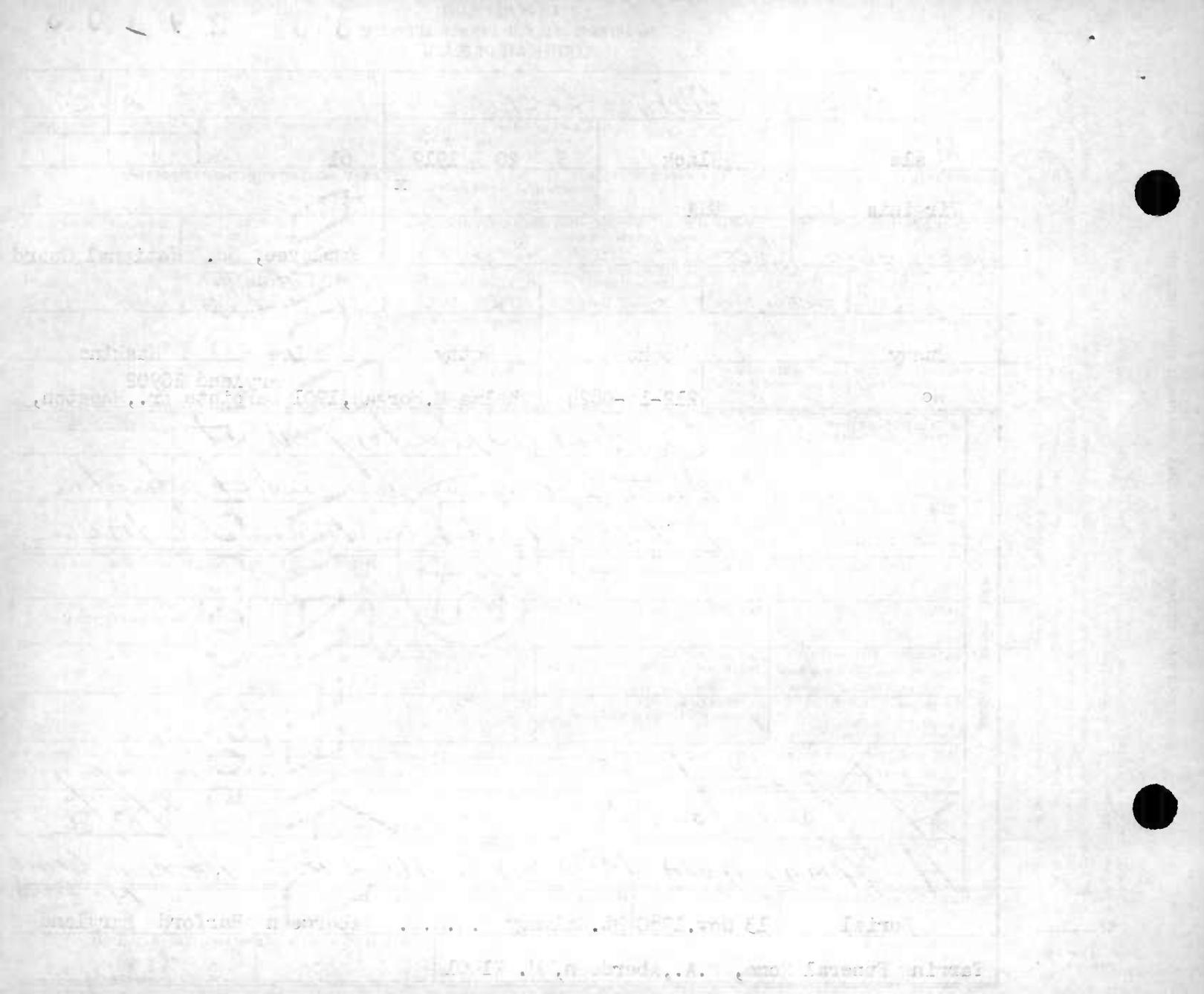
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 29.003	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
RICHARD ALVIN HASKINS						11-8-80						P 2:10 M	
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male			Black	MONTH DAY YEAR			61			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Virginia			USA						HARFORD				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Harford			Harford Memorial Hosp. Inc.			Employee, Md.			National Guard				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. COUNTY			13c. STREET ADDRESS				
			Md			Harford			101 Aberdeen Trace Apartments				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
Bunny				Cooks		Betty			Lee		Haskins		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS				
No			212-18-0824			Thelma M. Morgan, 1901 LaPointe Dr., Wheaton,			Maryland 20902				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4100 <i>Car doo exp'itory arrest</i>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												DUE TO, OR IS A CONSEQUENCE OF (b) <i>Acute &amp; massive myocardial infarction.</i>	
{ DUE TO, OR IS A CONSEQUENCE OF (c) <i>Atherosclerotic car doo vascular Disease</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO				
21a. ACCIDENT WAS UNDERLYING: <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 21c, PART 1 OR PART 2)							
21d. THE INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY 149 HOME, STREET, FACTORY, OFFICE, FARM, ETC.			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 11-8-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													
22b. SIGNATURE						DEGREE			23c. DATE SIGNED				
H. YAMAKAWA M.D.									8/8/80				
22c. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
H. YAMAKAWA M.D.			319 So. Union Ave. Harford			Aberdeen			Harford Maryland				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY	23f. STATE
Burial			13 Nov. 1980			Mt. Calvary U.A.M.E.			Aberdeen			Harford	Maryland
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Tarring Funeral Home, P.A., Aberdeen, Md. 21001						NOV 14 1980			<i>Larry Kennedy</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death.  
IMPORTANT: If item 21 is marked, or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 29004									
										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR					2b. HOUR								
Effie			MYRTLE		Heimiller	11 21 80					2:03 PM								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.										
FEMALE		WHITE		SEPT. 18, 1888			92												
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)									
MD		U.S.A.		Havre De Grace			Citizens Nsg. Home			HOME MAKER									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS										
MD		HARFORD		HAVRE DE GRACE			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		745 Ontario St										
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 720						16b. SOCIAL SECURITY NO		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for part 1a, b, c, d, e, f, g, h, i, j, k, l, m, n, o, p, q, r, s, t, u, v, w, x, y, z.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7970 old age		ADDRESS 3628 LEVEL VILLAGE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			b)			18. CAUSE OF DEATH (Enter only one cause per line for part 1a, b, c, d, e, f, g, h, i, j, k, l, m, n, o, p, q, r, s, t, u, v, w, x, y, z.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7970 old age						18. CAUSE OF DEATH (Enter only one cause per line for part 1a, b, c, d, e, f, g, h, i, j, k, l, m, n, o, p, q, r, s, t, u, v, w, x, y, z.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7970 old age		ADDRESS 3628 LEVEL VILLAGE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE							
22a. I certify that (I) (this hospital) attended the deceased from 11/21/80 to 11/21/80, that (I) (we) last saw the deceased alive on 11/21/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										22b. SIGNATURE DEGREE				22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. DATE SIGNED										
John D. Yun			Havre de Grace, Md.						11/21/80										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY		STATE					
BURIAL			Nov. 24, 1984			ANGEL HILL CEM.			HARFORD, MD.										
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE OF DEATH			25b. DATE OF BURIAL			25c. REGISTRAR'S SIGNATURE							
Mitchell P.H.P.A. HAVRE DE GRACE, MD.																			

BP \_\_\_\_\_

Alma 7

34

188-63102

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours. Page 4 may be retained by the hospital or attending physician.

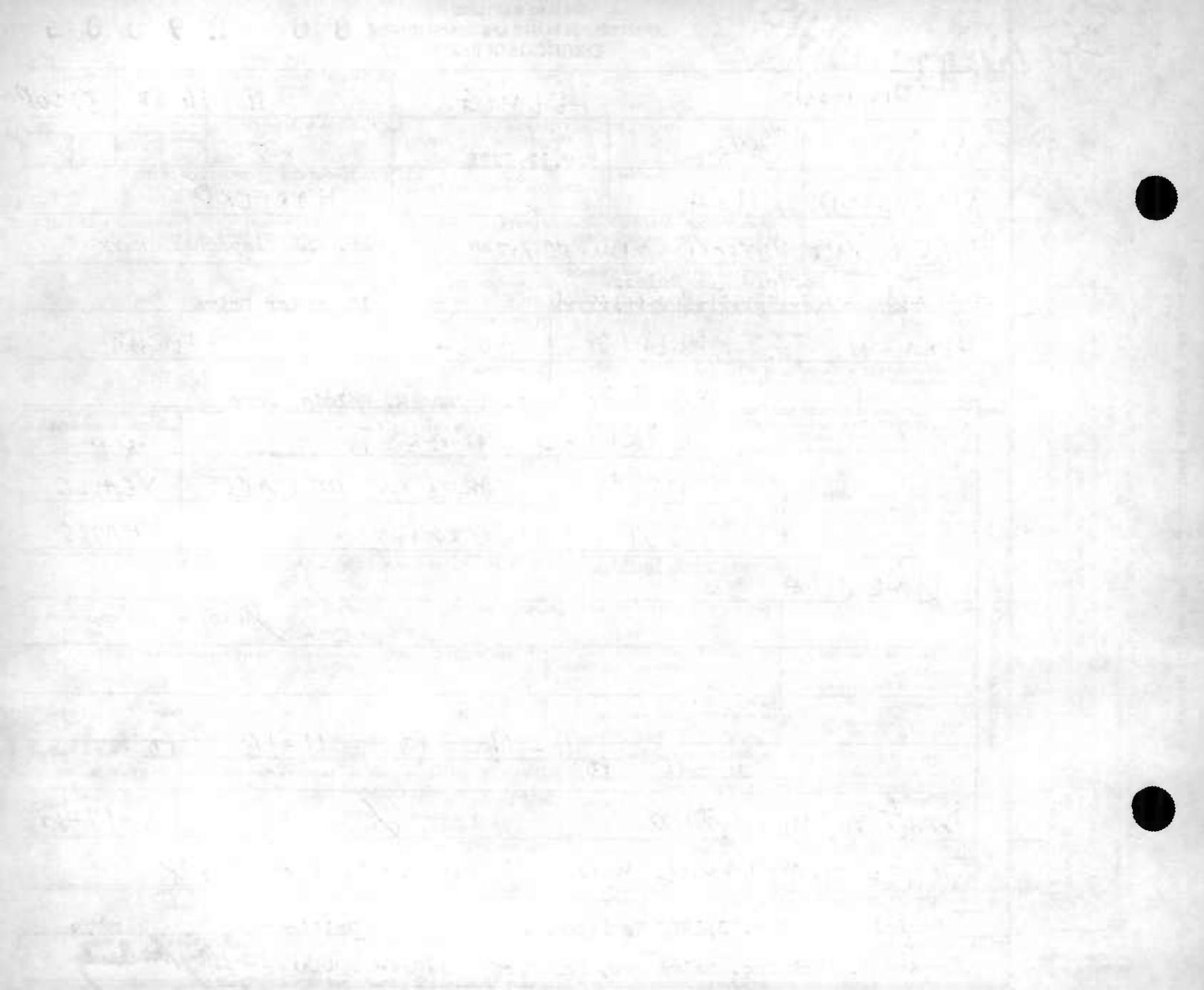
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 29005			
												REG. NO.			
1 - STATE REGISTRAR	Herman Helwig														
1. DECEASED NAME (TYPE OR PRINT)	FIRST		MIDDLE	LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
HERMAN				HELMIG			11 16 80					80	5:20P		
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)									
Male	White		Nov. 12, 1895			85									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
MARYLAND	USA						HARFORD								
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
HARFORD & GRACE	HARFORD Mem. HOSPITAL			Ret. Job Dispatcher			xx								
13a. STATE	13b. COLOR			13c. OPERATION			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Md.	brown			CKK 7254			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			12 Hunter Drive					
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	ADDRESS					
Herman		M.	HELMIG	ANNA			I.			FUCITS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
no	213-05-7733			Mr. Herman M. Helwig same			20 min								
18. CAUSE OF DEATH (Enter only one cause per line on 18a, b, c and d.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	4149			DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC ARREST			YEARS								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE			YEARS								
4149				DUE TO, OR AS A CONSEQUENCE OF (c) PERIODIC SCLEROSIS			YEARS								
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)	UREMIA														
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11-16 80 to 11-16 80, that (I) (we) lost soul the deceased alive on 11-16 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Dante M. Monakil				DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-17-80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE M. MONAKIL, M.D.	22e. ADDRESS HARFORD & GRACE, Md., 21078														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE Burial Nov. 20, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Parkwood			23d. LOCATION CITY OR TOWN Baltimore			COUNTY			STATE		
24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc.	ADDRESS Baltimore, Maryland						25a. DATE REC'D. BY REGISTRAR NOV 18 1980			25b. REGISTRAR'S SIGNATURE Ricky Helwig					

BP \_\_\_\_\_

DHMH-16 25M  
(VRA 15, 4) 1/79



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

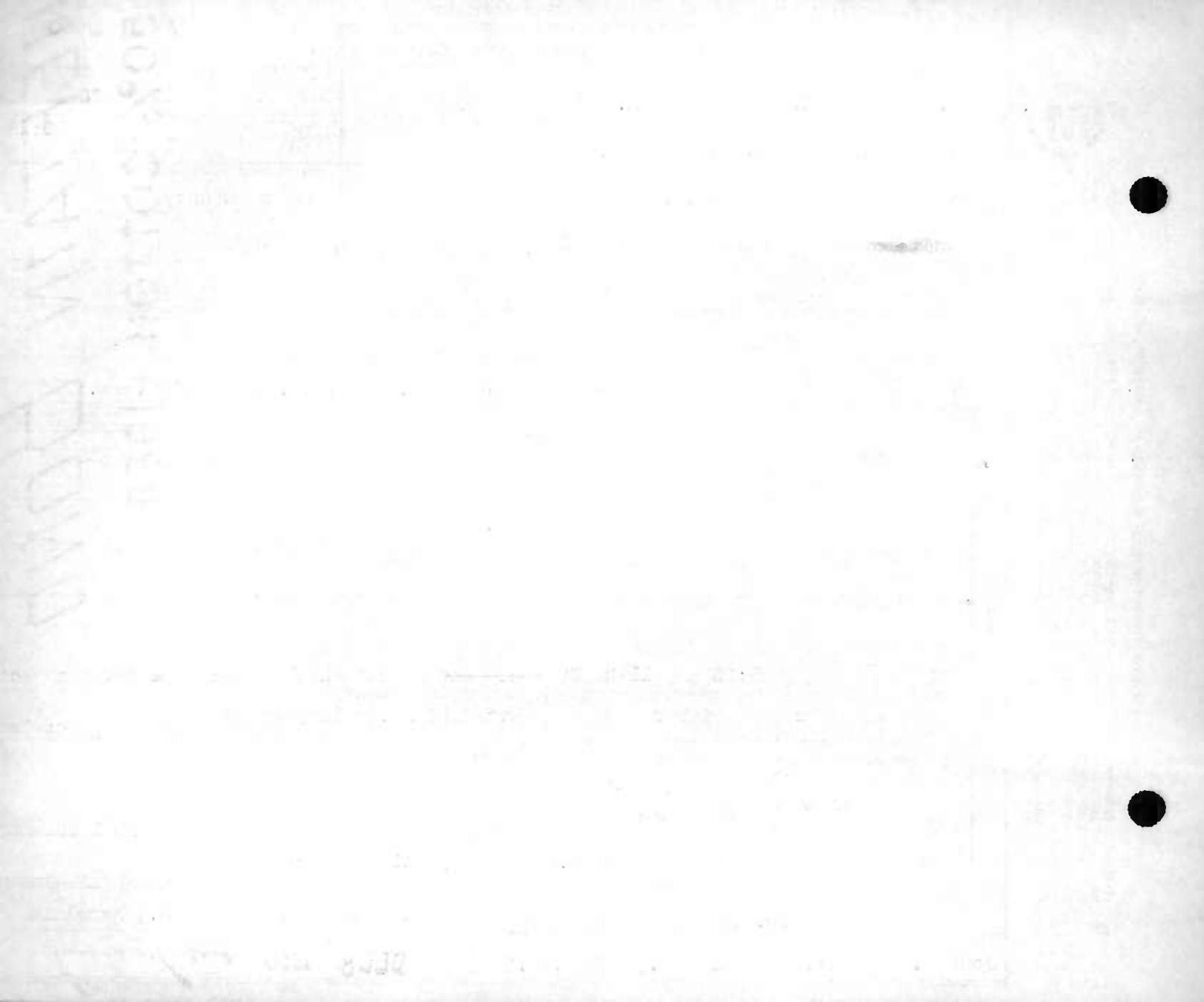
Item 21c G550 12/29/80 dad

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

29006

1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>DANNY</b>	MIDDLE <b>RAY</b>	LAST <b>HIRT</b>	2a. DATE KNOWN OF DEATH ESTIMATED MATED	MONTH <input checked="" type="checkbox"/> NOVEMBER	DAY 11	YEAR 30, 1980	2b. HOUR 10:15 p.m.
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH YEAR Aug. 17, 1962	6. AGE (IN YEARS) LAST BIRTHDAY 18 YRS.	7. IF UNDER 1 YR. MONTHS 0	8. IF UNDER 24 HRS. DAYS 0	9. DATE PRONOUNCED DEAD	MONTH NOVEMBER 11	DAY 30, 1980	10. HOUR 10:15 p.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford County</b>					
10. CITY OR TOWN OF DEATH <b>Whiteford</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Whiteford Rd. (rt.136)nr Deep Run Rd.</b>			12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Bel Air</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>2824 Forge Hill Road</b>						
14. FATHER'S NAME FIRST <b>Norman</b>			MIDDLE <b>Vallie</b>	LAST <b>Hirt</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Peggy</b>		LAST <b>Edwards</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>215-78-8526</b>		17. INFORMANT ADDRESS <b>Norman V. Hirt, R.D.3, Red Lion, Pa. 17356</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>Multiple injuries</b> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9:20 P.M. 11-30 1980</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Driver occupant of car which impacted a fixed object pinned in wreckage</b>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, HIGHWAY, ETC.) <b>highway</b>		21f. LOCATION <b>Whiteford Rd. (rt 136)nr Deep Run Road</b>						
22a. I certify that I took charge of the remains described above, held on <b>Autopsy</b> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										DATE SIGNED <b>12/1/80</b>
ACTUAL SIGNATURE <b>JRS Guard</b>										TITLE (SPECIFY) <b>M.D. Assistant MEDICAL EXAMINER</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>										ADDRESS <b>111 Penn Street</b>
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 5, 1980</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Bel Air Memorial Gdns.</b>		23d. LOCATION CITY OR TOWN <b>Bel Air, Harford Co., Maryland</b>				
24 FUNERAL DIRECTOR NAME <b>John H. Harkins, 600 Main St., Delta, Pa. 17314</b>		ADDRESS <b>John H. Harkins, 600 Main St., Delta, Pa. 17314</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 8 1980</b>		25b. REGISTRAR'S SIGNATURE <b>John H. Harkins</b>				
DHMH-17 (VR A15 ME (5)) 15M 2/80										



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 29007														
1. DECEASED NAME (TYPE OR PRINT)			FIRST Joseph			MIDDLE J.			LAST Hoch			2a. DATE KNOWN OF ESTI. DEATH MATED			MONTH DAY YEAR		2b. HOUR 2:18 P.M.									
3. SEX Male			4. RACE W			5. DATE OF BIRTH MONTH 7 DAY 31 YEAR 99 LAST BIRTHDAY 81 YRS.			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.					2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR		2d. HOUR 2:18 P.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford County																	
10. CITY OR TOWN OF DEATH Fallston			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Conductor Retired			12b. KIND OF BUSINESS OR INDUSTRY L.I. RAILROAD																	
13a. STATE Md.			13b. COUNTY Harford			13c. CITY OR TOWN Fallston			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 1300 Malus Ct.														
14. FATHER'S NAME FIRST HENRY			MIDDLE			LAST HUCH			15. MOTHER'S MAIDEN NAME FIRST HENRIETTA			MIDDLE			LAST N/A											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WWI			16c. INFORMANT Joseph M. Hoch			17. ADDRESS Same As # 13																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4292 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF  (c) DUE TO, OR AS A CONSEQUENCE OF																										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>																				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE																				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																										
ACTUAL SIGNATURE <u>Samuel H. Henck</u>			TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER 721 Wheeler School Road Whiteford, Md. 21160			DATE SIGNED <u>11/30/80</u>																	
EXAMINER'S NAME (TYPE OR PRINT) <u>Samuel H. Henck, M.D.</u>			ADDRESS <u>Whiteford, Md. 21160</u>			23a. LOCATION CITY OR TOWN PINELAWN			23b. LOCATION CITY OR TOWN PINELAWN																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>12/3/80</u>			23c. NAME OF CEMETERY OR CREMATORIAL LONG ISLAND NATIONAL			23d. LOCATION CITY OR TOWN SUFFOLK			23e. COUNTY N.Y.														
24. FUNERAL DIRECTOR NAME <u>E. Barnes</u>			ADDRESS <u>FLEMING FUNERAL SERVICE</u>			24a. DATE REC'D. BY REGISTRAR BENSON, MD. 21018 DEC 1 1980			24b. DATE REC'D. BY REGISTRAR BENSON, MD. 21018 DEC 1 1980																	

1870-1871

W. H. C. T. M.

1871

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 0 2 9 0 0 8		
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			Stella Brooks			Howell			11 20 1980					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female			White			5 15 1904			76			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			M.D.		
N. C.			U.S.A.						Harford					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Havre De Grace			313 Robin Hood Rd.						Housewife					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
Pa.			Chester			Toughkenamon						union st.		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Cephus mn Brooks			Elizabeth N.M.N. Neice											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for item (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No			197-12-2212			Robert Howell			750 Lafayette St. Kennett Square Pa.			-		
1990						cancerous ulcer								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)			DUE TO, OR AS A CONSEQUENCE OF								
			(c)			DUE TO, OR AS A CONSEQUENCE OF								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11/19/80, 19, to 11/20/80, 19, that (I) (we) last saw the deceased alive on 11/19/80, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE John H. Wachsmann						DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/20/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Irvin H. Wachsmann						22e. ADDRESS 407 S. UNION Ave 1700 S. Calhoun St. Baltsmore								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/22/1980			23c. NAME OF CEMETERY OR CREMATORY Holly Hill Mem. Park			23d. LOCATION CITY OR TOWN Baltimore			COUNTY STATE Md.		
24. FUNERAL DIRECTOR NAME Fannington + Son			225 ADDRESS 225 Washington Havre De Grace, Md.			25a. DATE REC'D. BY REGISTRAR NOV 21 1980			25b. REGISTRAR'S SIGNATURE R. J. Schaefer					



000 13430

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR RECORDS.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

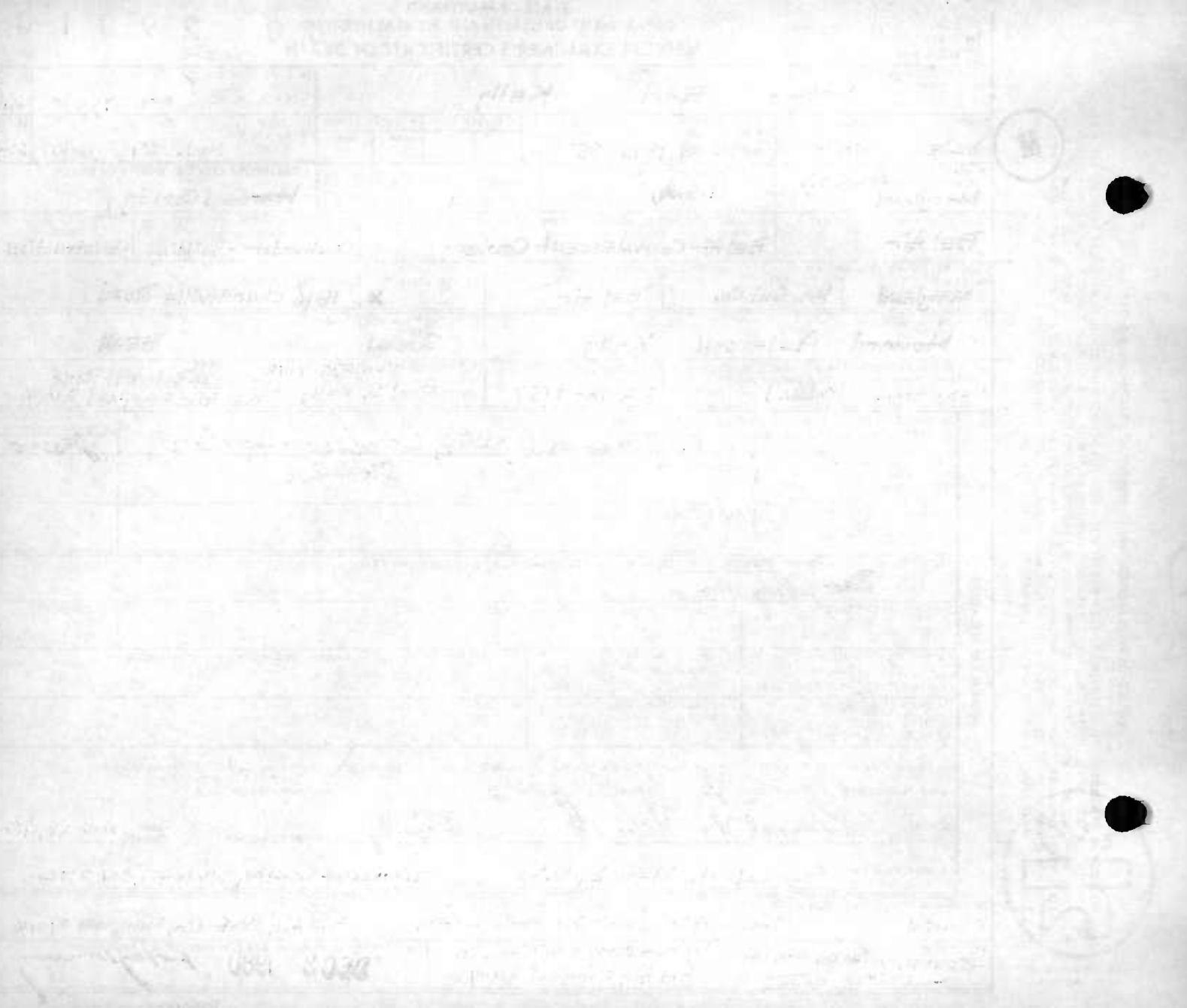
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 30 29009		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	Keiser				20. DATE KNOWN OF DEATH MATED	MONTH DAY YEAR	2b. HOUR		
Allen				HENRY	Keiser					<input type="checkbox"/> 11 9	19 80	10:52 M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN	2c. DATE PRONOUNCED DEAD	MONTH DAY YEAR	2d. HOUR		
M	W	July 23 1940	70							11 - 9	19 80	10:52 M		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY			8.	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				
York County, Pa.		USA								Harford				
10. CITY OR TOWN OF DEATH												11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Fallston												Fallston Gen Hosp	Human Fact. Eng	Govt.
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN							208 Garnett Rd.					
Maryland	Harford	Joppa												
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Allen Leroy Keiser			Jenny Mae Hempfing											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
VIETNAM			173-32-6600			Margie J. Keiser			208 Garnett Rd. Joppa, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>cardiac arrest</u>												minutes		
4100 Conditions, if any, which give rise to immediate cause (a) stating the under- lying cause last: } DUE TO, OR AS A CONSEQUENCE OF														
(b) <u>coronary artery occlusion</u> 2 hours } DUE TO, OR AS A CONSEQUENCE OF														
(c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?		
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE		TITLE (SPECIFY) <u>Samuel H. Henck, M.D.</u> Deputy MEDICAL EXAMINER										DATE SIGNED <u>11/10/80</u>		
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS <u>721 Wheeler School Rd. White Ford</u>												
23a. BURIAL CREMATION REMOVAL (SPECIFY)			23b. DATE REMOVAL - BURIAL Nov 13, 1980			23c. NAME OF CEMETERY OR CREMATORIUM RESTHAVEN CEMETERY			23d. LOCATION CITY OR TOWN Hanover			23e. COUNTY YORK	23f. STATE PA.	
24. FUNERAL DIRECTOR NAME <u>Howard K. McComas III</u> ADDRESS <u>Abingdon, Maryland</u>									25a. DATE REC'D. BY REGISTRAR <u>NOV 12 1980</u>			25b. REGISTRAR'S SIGNATURE <u>Ricky McCrady</u>		
DHMH - 17 (VR A15 ME (5)) 30M 7/73														



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 29010
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTI- MATED			MONTH	DAY	YEAR	2b. HOUR P. 6:15 M
NELSON			EARL	KELLY		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	NOV. 29,	1980		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR P. 6:15 M
MALE	White	Sept. 29, 1895	85 yrs.	MONTHS	DAYS	HOURS	MIN.	Nov. 29,	1980			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH Harford County									
10. CITY OR TOWN OF DEATH Bel Air	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Convalescent Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contractor - Building	12b. KIND OF BUSINESS OR INDUSTRY Construction									
13a. STATE Maryland	13b. COUNTY Harford Co.	13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 1816 Churchville Road								
14. FATHER'S NAME First: Howard Middle: Anderson Last: Kelly	15. MOTHER'S MAIDEN NAME First: Susan Middle: Beall Last:											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES - Army	16b. SOCIAL SECURITY NO. W.W. I	16c. INFORMANT (SON) 838-4148 ADDRESS Mr. Earl S. Kelly 122 West Belcrest Road Bel Air, Maryland 21014										
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4292 years. Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Emphysema												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE	TITLE (SPECIFY) M.D. <u>Samuel H. Henck</u> Deputy										MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS 721 Wheeler School Rd., Whiteford, Md. 21160										DATE SIGNED Nov. 29, 1980	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE DEC. 2, 1980	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Meth. Ch. Cem.	23d. LOCATION CITY OR TOWN Bel Air, Harford Co., Maryland 21014	23e. COUNTY Harford Co.	23f. STATE Maryland							
24. FUNERAL DIRECTOR Joseph William Foster	ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014	25a. DATE REC'D. BY REGISTRAR DEC 2 1980	25b. REGISTRAR'S SIGNATURE <u>John J. Murphy</u>									
DMHMH-17 (VR A15 ME (5))	15M 7/77											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MED. EXAM.CERT.			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8 0 2 9 0 1 1							
1. FOR STATE REGISTRAR			REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
Elsie			Mary	Kershaw		11/24/80						8:35 A.M.				
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR					
FEMALE			White		July 7, 1910			70			MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NYC New York			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Fallston			Fallston General Hospital		Housewife			Homemaker								
13a. STATE			13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS								
Maryland			Harford Co.		Bel Air			308 Lee Way								
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST					
CHARLES			ANDREW	HASLACKER		Marry			Elizabeth		HESSE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT (DRAFT) 5357 TANEY AVE.-APT. 106 ALEXANDRIA, VA 22304			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO			218-46-3903		Miss. Mary E. Kershaw						years					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic cardiovascular disease													
4292			DUE TO, OR AS A CONSEQUENCE OF (b)													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Natural, Inspection Inquiry Samuel H. Henck, M.D.			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			Deputy Medical Examiner			22c. DATE SIGNED 11/24/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Samuel H. Henck, M.D.			22e. ADDRESS 721 Wheeler School/Rd. Md. 21160													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Nov. 25, 1980		23c. NAME OF CEMETERY OR CREMATORIAL Green Mount Crematory		23d. LOCATION CITY OR TOWN Baltimore, Maryland			COUNTY STATE						
24. FUNERAL DIRECTOR Joseph William Foster			ADDRESS Bed Air, Maryland 21014		25a. DATE ADDED BY REGISTERAR Nov 26 1980			25b. REGISTRATION NUMBER 100-00000000								



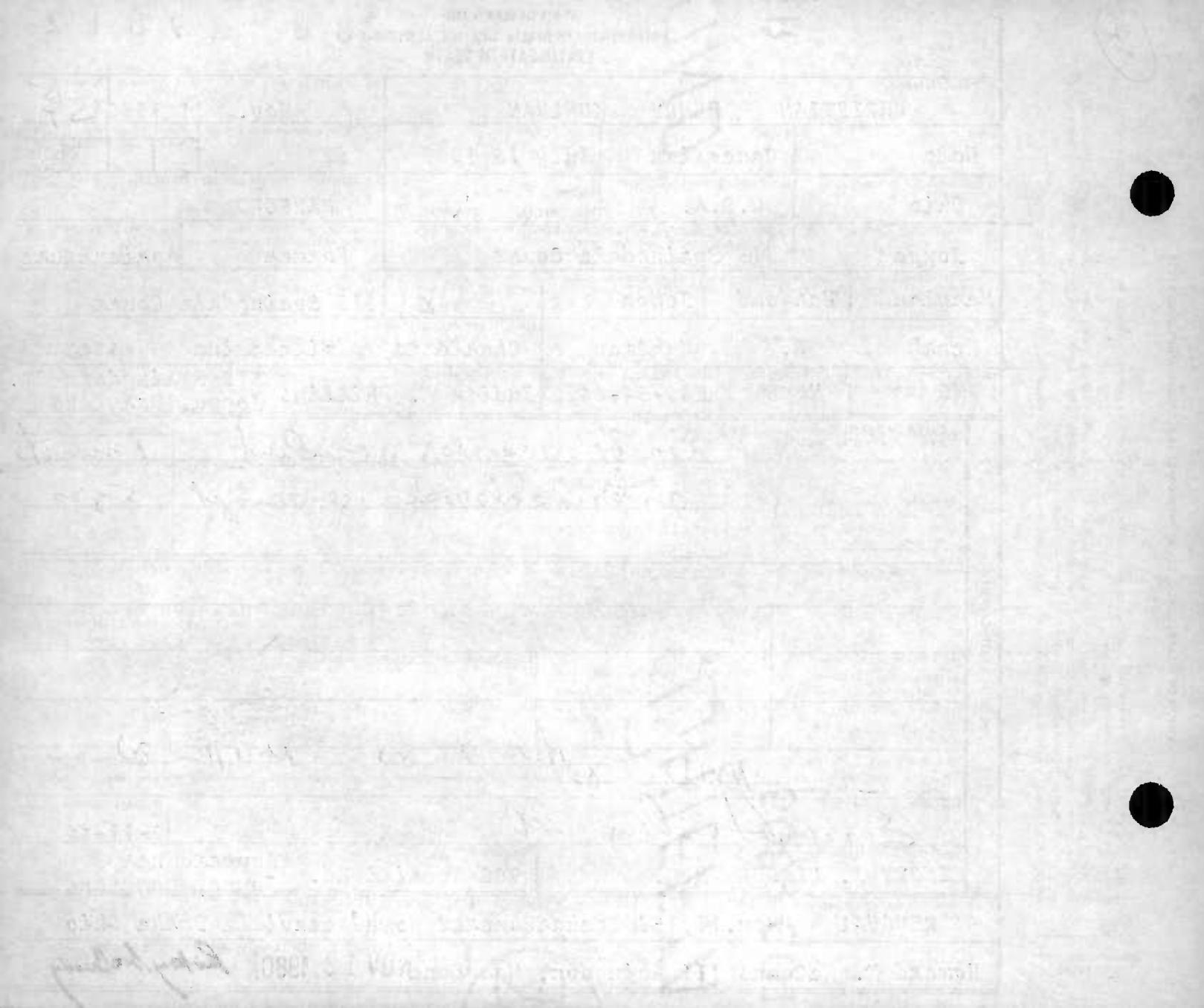
1000 SVOK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 29012			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR	
CHRISTIAN HENRY KUHLMAN							Nov. 11 1980						11 1980	5:15 PM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		Caucasian		July 16 1898			82				MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			9. BALTIMORE CITY OR COUNTY OF DEATH				YRS.				
Ohio		U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			HARFORD								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Joppa		315 Springdale Court				Farmer				Agriculture					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS				
Maryland		Harford		Joppa							315 Springdale Court				
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST				LAST				
Henry		A.		Kuhlman			Charlotta				Wilhelmina Kester				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE DATE OF BIRTH)		17. INFORMANT Judith A. Phillips				ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO		NONE		288-34-8622				Joppa, Maryland				515 Springdale Ct.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												month			
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												Cerebrovascular accident			
DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis, generalized												5 yrs			
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from Nov. 7, 1980, to Nov. 11, 1980, that (I) (we) last saw the deceased alive on Nov. 7, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.															
22b. SIGNATURE Emory J. Linder M.D.												22c. DATE SIGNED 9-11-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>			
EMORY J. LINDER M.D.			902 Averill Rd.			Joppatowne									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE			
REMOVAL			Nov. 11, 1980			Zechar Funeral Home Greenville Darke Ohio									
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REC'D. REGISTRAR'S SIGNATURE						
Howard K. McComas III Abingdon, Maryland						NOV 12 1980			Ricky McComas						



X  
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

29013

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2d. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2d. HOUR
<i>Donald T. Linebaugh</i>							<input type="checkbox"/>	11	17	80	7:55 AM
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD			2d. HOUR
M	W	7-20-14	66 yrs.					MONTH	DAY	YEAR	11 17 80 19 AM
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.		
PA.		USA			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		HARFORD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Fallston		Fallston Hospital			Retired						
13a. STATE		13b. COUNTY		13c. CITY, OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Md.		HARFORD		Street				113 CREEKVIEW DR.			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		LAST			
TRA		O.		LINEBAUGH		MARY		V. SMITH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
(If Yes, Give War or Dates) WW2		182-01-1096		Hospital Charl							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF 4149 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
CORONARY Heart Disease ASCOVD.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>L. Lengel</i>		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 464 Allaire St HARFORD									
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 11-20-80		23c. NAME OF CEMETERY OR CREMATORIAL BELAIR MEM. GARDENS			23d. LOCATION CITY OR TOWN BEL AIR HARFORD		COUNTY MD.		
24. FUNERAL DIRECTOR NAME JOHN H. HARKINS, DELTA, PA.		ADDRESS 17314		25a. DATE REC'D. BY REGISTRAR NOV 24 1980			25b. REGISTRAR'S SIGNATURE <i>Henry McCreary</i>				

W



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Gail Austin Low						Nov. 21 1980			1980	9:05 P	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		white		Month	Day	Year	YRS.	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
Pa.		USA		Nov. 22 1932		57					
9. BALTIMORE CITY OR COUNTY OF DEATH		Harford MD.									
10. CITY OR TOWN OF DEATH		Havre de Grace HARFORD memorial Hospital									
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		12b. KIND OF BUSINESS OR INDUSTRY	
MD		HARFORD		Edgewood		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2104 Rail Road		BLOCK OPERATOR AMTRACK	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Boyd		C.		Low		Alda		N.Y.		STATES	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		5136 ONION RD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO		310-12-3789		Ronald Low		FAWN GROVE PA.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) EXTENSIVE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/20/1980 to 11/21/1980, that (I) (we) lost saw the deceased alive on 11/20/1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dante Monakil		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/21/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE U. MONAKIL		22e. ADDRESS Havre de Grace, MD 21078									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11-25-80		23c. NAME OF CEMETERY OR CREMATORY White Church Cemetery		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Pennington & Son		ADDRESS 995 S Washington		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE R. J. Monakil					
BP _____											

10



1000



ONE & EIGHT



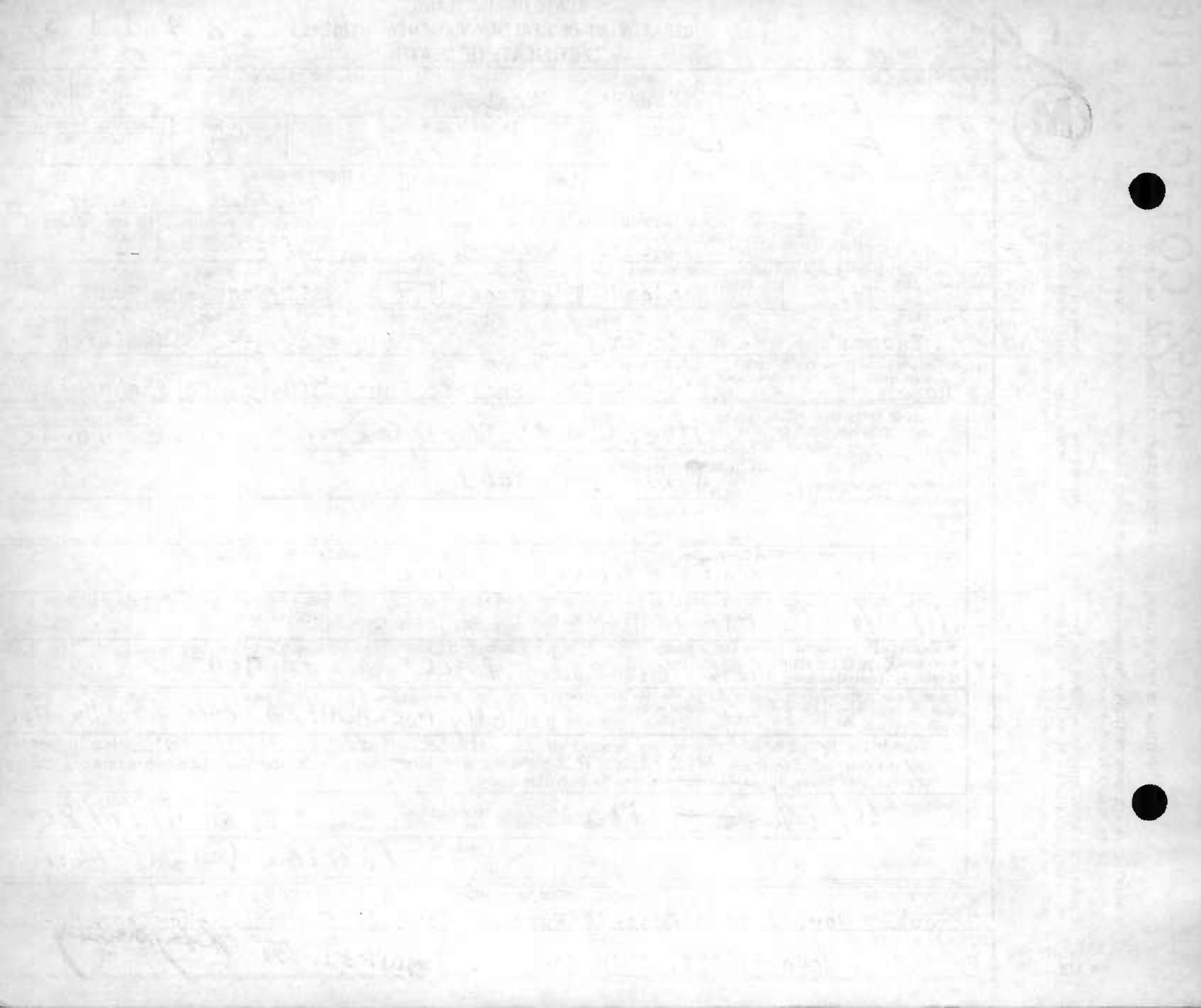
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the office of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 24 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

29015

1. DECEASED NAME (Type or print)	First <i>ELIZABETH</i>	Middle <i>KEDAR</i>	Last <i>MACLEOD</i>	2a. DATE OF DEATH Month <i>11</i>	Day <i>21</i>	Year <i>80</i>	2b. HOUR <i>10 P.M.</i>
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>08-19-83</i>			6. AGE (In years last birthday) <i>94</i> YRS.	IF UNDER 1 YEAR MONTHS <i>94</i>	IF UNDER 24 HRS. HOURS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Scotland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH <i>HARFORD COUNTY</i>			
10. CITY OR TOWN OF DEATH <i>FALLSTON</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>FALLSTON GEN. HOSP.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>--</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>33 Md.</i>	13b. COUNTY <i>Harford</i>	13c. CITY OR TOWN <i>Edgewood</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES	13e. STREET AND NUMBER <i>611 Hornbeam Road</i>			
14. FATHER'S NAME First <i>Thomas</i>	Middle <i>--</i>	Lost <i>Kedar</i>	15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i>	Middle <i>--</i>	Lost <i>Hamilton</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16b. SOCIAL SECURITY NO. <i>214-74-0062</i>	17. INFORMANT <i>Russell Funeral Home, Conshohocken, Pa.</i>	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MYOCARDIAL INFARCTION</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 Hour</i>	
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>ATHEROSCLEROSIS</i> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <i>(L)IMA fracture following fall.</i>							
19c. MEDICAL CERTIFICATION		19a. DATE OF OPERATION <i>11/21/80</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>(L)IMA fracture</i>	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>--</i>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>10</i> Month Day Year <i>11 20 1980</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>FALL OUT OF BED</i>				
21d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>Home</i>	21f. LOCATION Street or R.F.D. No. <i>611 HOENBEAM RD</i>	City or Town <i>EDGWOOD</i>	County <i>Harford</i>	State <i>Md.</i>	
22a. I certify that <i>(L)IMA fracture</i> attended the deceased from <i>Nov 21 1980</i> to <i>11/21 1980</i> , that <i>(I) (we) (did) (did not)</i> last saw the deceased alive on <i>Nov 21 1980</i> and that in <i>(my) (our)</i> opinion death occurred on the date and hour and from the causes stated above, <i>(I) (we) (did) (did not)</i> view the body after death.							
22b. SIGNATURE <i>A. J. Scott</i>		70.	DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	<input checked="" type="checkbox"/>	22c. DATE SIGNED <i>11/21/80</i>
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>Fallston Gen. Hosp.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>Nov. 22, 1980</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Russell Funeral Home Conshohocken Mont.gomery-Pa.</i>	23d. LOCATION (City or Town) <i>Montgomery-Pa.</i>	(County)	(State)		
24. FUNERAL DIRECTOR <i>Howard K. McComas III, Abingdon, Md.</i>	25a. REC'D BY REGISTRAR <i>NOV 25 1980</i>			25b. REC'D BY SIGNATURE <i>Howard K. McComas III</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 29016		
												REG. NO.		
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			Elizabeth E.			Martin			11 26 1980			9 05 PM		
3 SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female			white			6 21 1893			87			YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 20 HRS		
Pennsylvania			USA						Harford			MONTHS DAYS HOURS MIN.		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Harford de Grace			Harford Methodist Hospital			Homemaker			Home					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
Md.			Harford			Aberdeen			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			14 N. Rogers St.		
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Thomas Kane			Margaret Donnelly											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES No			16b. SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS					
			212-32-0594			Mary R. Martin, Apt. 1235, 1900 W. Polk, Chicago, Illinois 60612								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ca of Colon &amp; Metastase</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>month</i>		
1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) (c)														
DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11-23</u> , 19 <u>80</u> , to <u>11-26</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11-26-</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>John P. de los Santos</i>			DEGREE <i>deg</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>11-27-80</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
<i>Rene P. de los Santos</i>			2835 Churchville Rd, Churchville, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <u>Burial</u> <u>1 Dec. 1980</u>			23c. NAME OF CEMETERY OR CREMATORIAL St. Francis de Sales			23d. LOCATION CITY OR TOWN <u>Abingdon</u> COUNTY <u>Harford</u> STATE <u>Maryland</u>					
24 FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR <u>Dec 1 1980</u>			25b. RECORDED BY <u>John P. de los Santos</u>					
Tarring Funeral Home, P.A., Aberdeen, Md. 21001														

5 10 15 20

2000 hours

Cloudy today with light rain at times

2

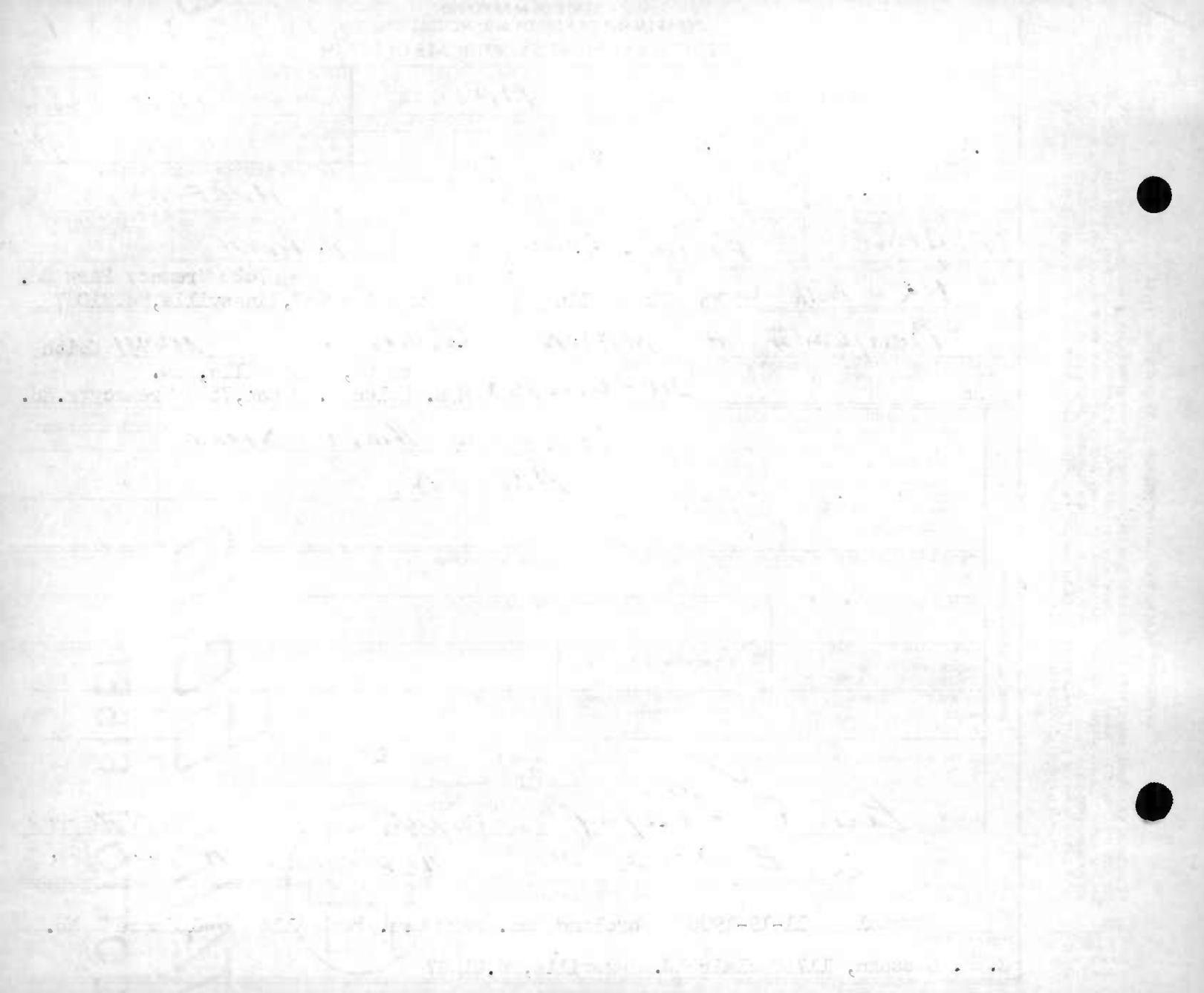
Cloudy with some rain in the afternoon

0000 1930

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 5029017				
1- FOR STATE REGISTRAR			2e. DATE KNOWN OF ESTI- DEATH MATED									2b. HOUR 8PM				
1 DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2e. DATE MONTH DAY YEAR	2b. HOUR 8PM			
Howard R MASON												11 16 80				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE MONTH DAY YEAR		2d. HOUR 8PM		
M		W		12 14 03		76 yrs.						11 16 19 80		M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. MARRIED NEVER MARRIED WIDOWED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH				
Baltimore			USA									Harford				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Fallston			Fallston General			Retired										
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		
			Md.			Baltimore County			Kingsville					7620 Gremecy Park Rd.		
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST				
Benjamin H			Mason						Katherine			Keith				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
no			218-01-5993			Box 67, Kingsville, Md.			Mrs. Helen M. Mason, 7620 Gremecy Pk. Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																
PART I DEATH WAS CAUSED BY:																
IMMEDIATE CAUSE (a) <i>Coronary Heart disease</i>																
DUE TO, OR AS A CONSEQUENCE OF																
4149 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u>																
(b) <i>ASCVD</i>																
DUE TO, OR AS A CONSEQUENCE OF																
(c)																
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?				
															YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion																
death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE <i>Louis E. Renfro</i>			M.D.			TITLE (SPECIFY) <i>Deputy</i>			MEDICAL EXAMINER			DATE SIGNED 11-16-80				
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 11-19-1980			23c. NAME OF CEMETERY OR CREMATORIAL Moreland Mem. Park Cem.			23d. LOCATION CITY OR TOWN Parkville			23e. COUNTY STATE				
24. FUNERAL DIRECTOR NAME E. F. Lassahn,			ADDRESS 11750 Belair Rd. Kingsville, Md. 21087			25a. DATE REC'D. BY REGISTRAR Nov 19 1980			25b. REGISTRAR'S SIGNATURE <i>Henry McReady</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in in the funeral director's page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within the office of the medical examiner with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 29018			
												REG. NO.			
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			Florence S. McCann						November 10, 1980			7 32 PM			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Female			White			October 13, 1902			78			MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS			
Maryland			U.S.A.						Harford			YRS.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Harve de Grace			Harford Memorial Hospital			Assembly Line			R.M.R.C.						
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
Maryland			Cecil			Port Deposit			104 A Principio Road						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
FIRST William			MIDDLE Sharon			FIRST Anna			MIDDLE Bell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
no			212-18-4465			Vivian West, Chamberlayne Rd., Newark, Del.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u> Plaque multata															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from Oct 16, 1980, to Nov 10, 1980, that (I) (we) last saw the deceased alive on Nov 10, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.														22c. DATE SIGNED	
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS												
John D. Yun			Anne de Grace												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 13, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Charlestown Cemetery			23d. LOCATION CITY OR TOWN Charlestown, Cecil, Maryland			STATE			
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Maryland.			ADDRESS			25a. DATE REC'D. BY REGISTRAR NOV 18 1980			25b. REGISTRAR'S SIGNATURE Patterson & Son						

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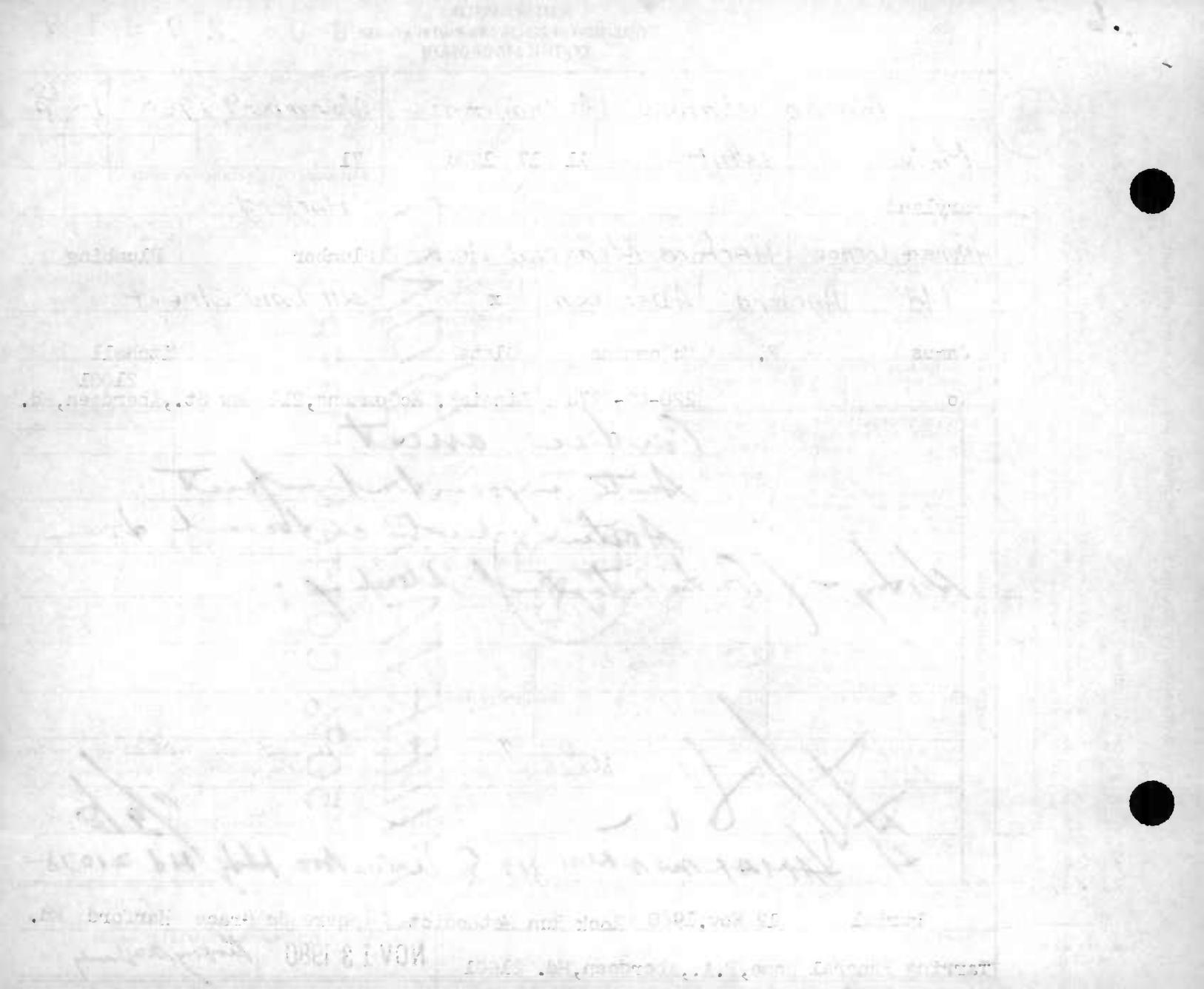
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 80 29019					
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR November 9, 1980									2b. HOUR 12 PM					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 24 HRS					
Marvin Winfield McCommons						11 17 1908			71			MONTHS DAYS		HOURS MIN.			
7. SEX			4. RACE			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Male			White			USA						Harford					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Harve de Grace			Harford Memorial Hosp.									Plumber			Plumbing		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS							
Md			Harford		Aberdeen					211 Law Street							
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
James F. McCommons			Oleta Mitchell														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.									17. INFORMANT ADDRESS		21001 Linnier. McCommons, 211 Law St., Aberdeen, Md.			
No			220-09-2274														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute myocardial infarct</i> (c) <i>Arteriosclerotic cardiovascular disease</i>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <i>History of hypertension, bleeding</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) this hospital attended the deceased from 11-9, 1980, to 11-9, 1980, that (I) (we) last saw the deceased alive on 11-9, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.														22b. SIGNATURE			
														DEGREE			
22c. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 11/9/80			
H. J. Tarrington MD			319 So Union Ave Aberdeen, Md. 21001														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE			
Burial			12 Nov. 1980			Rock Run Methodist			Havre de Grace			Harford		Md.			
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR									25b. REGISTRAR'S SIGNATURE					
Tarring Funeral Home, P.A., Aberdeen, Md. 21001			NOV 13 1980									Hector McBrady					
DHMH-16 30M 2/80 (VRA 15, 4)																	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

6029020

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
<i>Bernard</i>			<i>Patrick</i>	<i>mc NAMARA</i>		<input checked="" type="checkbox"/>	11	2	1980	12:01 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
<i>m</i>	<i>w</i>	MONTH <i>2</i> DAY <i>17</i> YEAR <i>15</i>	<i>65</i> yrs.	MONTHS	DAYS	HOURS	MIN			3 A.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH			
<i>Maryland</i>		<i>USA</i>			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		<i>HARFORD</i>			MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
<i>FAULKSTON</i>	<i>FAULKSTON GEN Hospt</i>	<i>Br</i>	<i>chief, Toxicology US-govt.</i>

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS
<i>Maryland</i>	<i>Harford</i>	<i>Joppa</i>		<i>613 Magnolia Road</i>

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
<i>Patrick</i>	--	<i>McNamara</i>	<i>Annie</i>	--	<i>Evans</i>

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input checked="" type="checkbox"/> Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WWII 216-07-5160</i>	17. INFORMANT <i>Mrs. Priscilla D. McNamara, Joppa, Md.</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  4149 IMMEDIATE CAUSE (a) <i>Ventricular Fibrillation</i> Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause last:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
{ DUE TO, OR AS A CONSEQUENCE OF (b) <i>coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>arteriosclerotic cardiovascular dis</i>			<i>not known</i>
years.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).			

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
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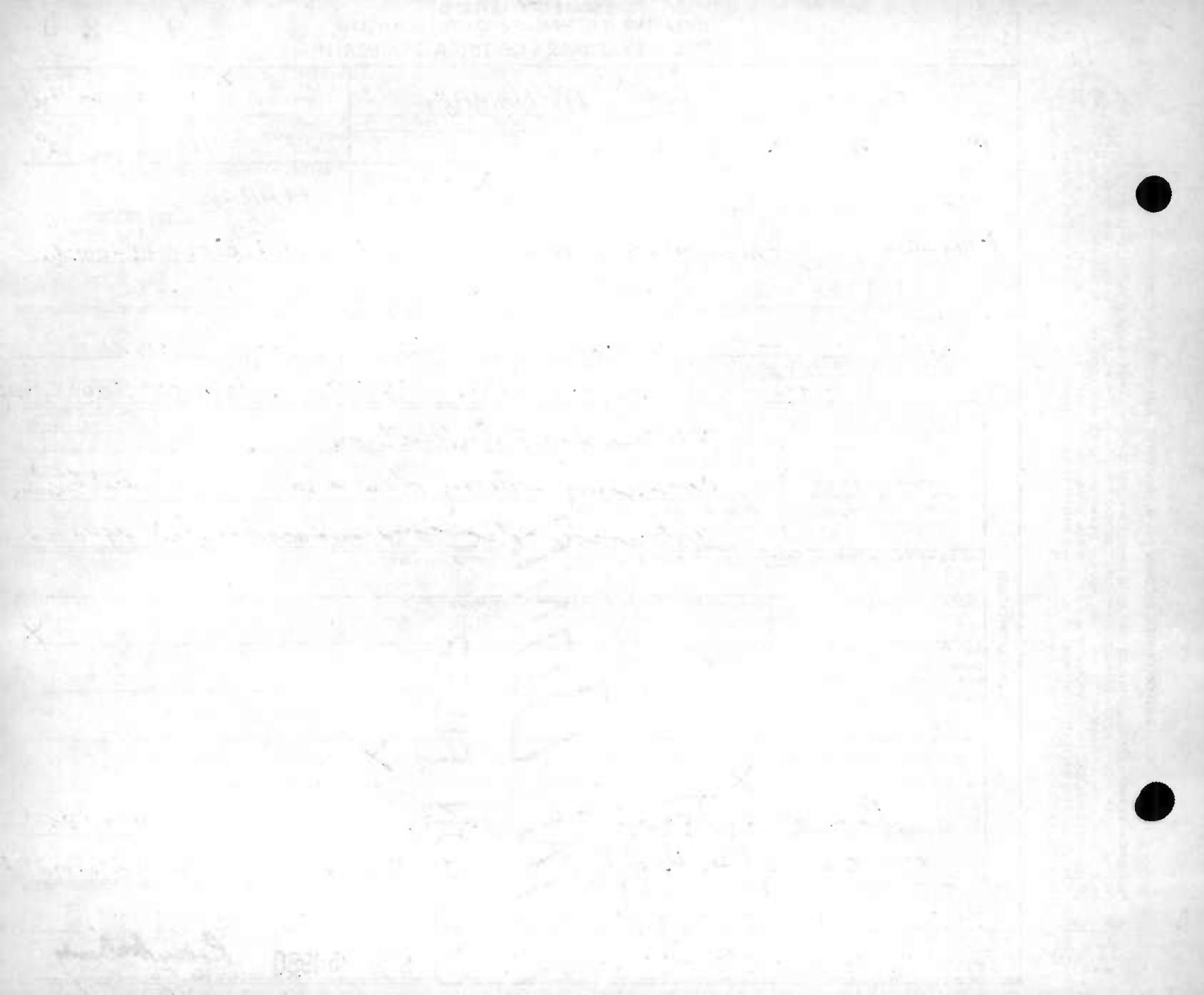
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>	and in my opinion
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ACTUAL SIGNATURE <i>Samuel H. Hench, M.D.</i>	TITLE (SPECIFY) <i>Deputy</i>	MEDICAL EXAMINER	DATE SIGNED <i>11/2/80</i>
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EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS <i>721 Wheeler School Rd., Whiteford, Md.</i>
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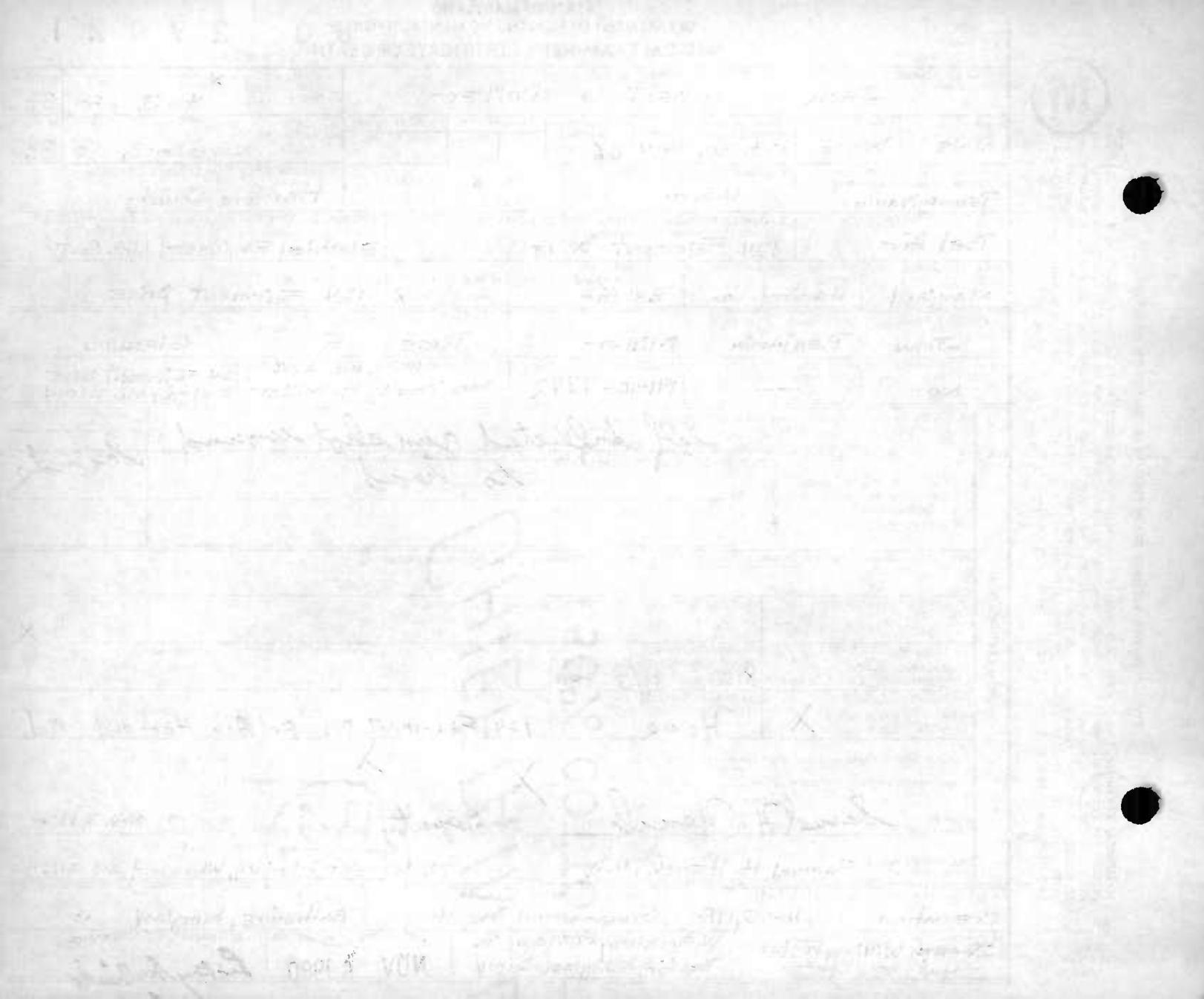
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE <i>Burial Nov. 5, 1980</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Bel Air Mem. Gardens</i>	23d. LOCATION CITY OR TOWN <i>Bel Air Harford Md.</i>
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24. FUNERAL DIRECTOR NAME <i>Howard K. McComas III, Abingdon, Md.</i>	ADDRESS	25a. DATE REC'D. BY REGISTRAR <i>NOV 5 1980</i>	25b. REGISTRAR'S SIGNATURE <i>Peter J. Hench</i>
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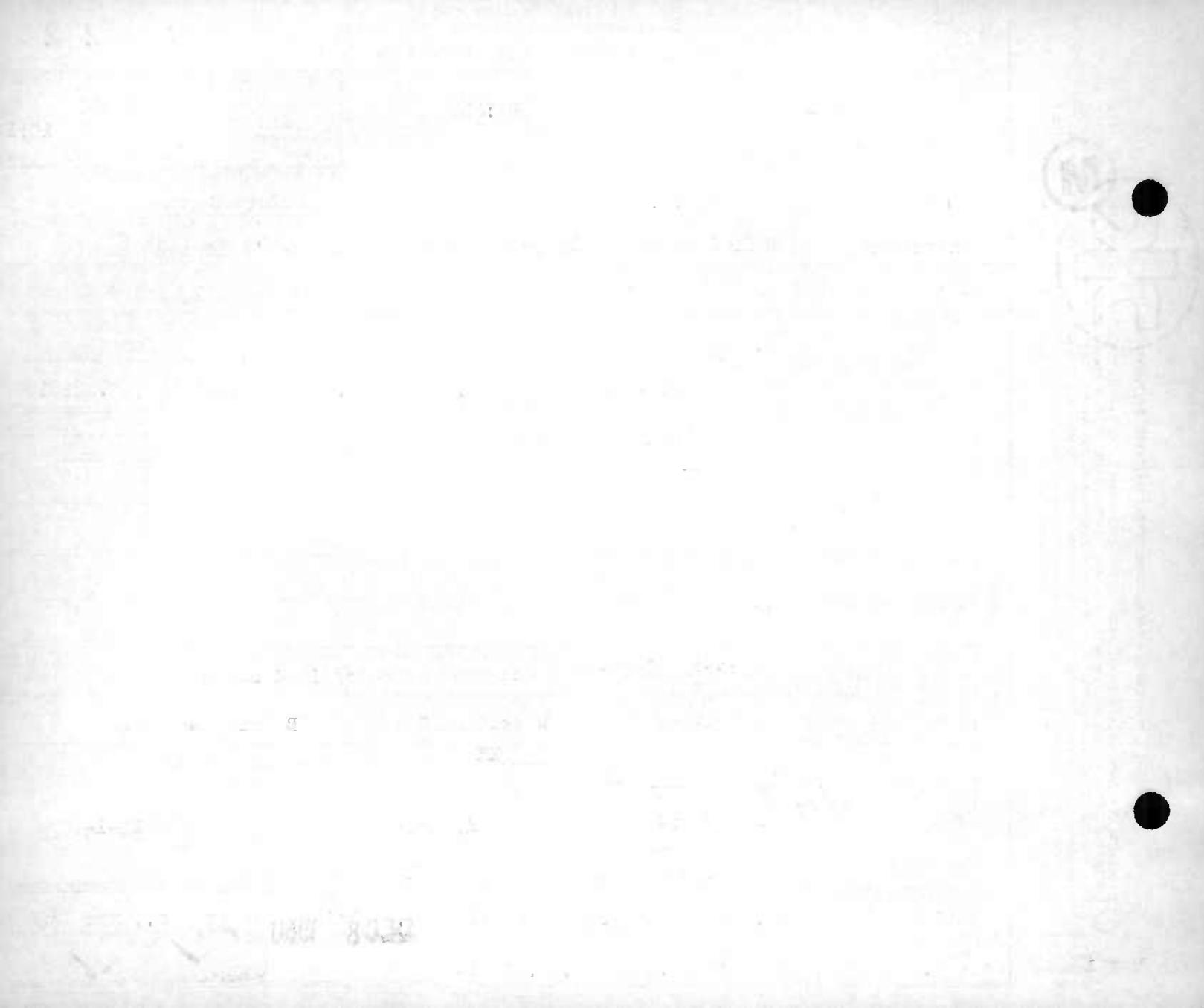
10 29021

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.										
1- STATE REGISTRAR																						
1. DECEASED NAME (TYPE OR PRINT)		FIRST JACK			MIDDLE Albert			LAST Miller			2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH NOV. 3, 1980	DAY	YEAR	2b. HOUR 8P.M.							
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH Oct. 30, 1914		YEAR DAY		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. DAYS		HOURS		MIN.		2c. DATE PRONOUNCED DEAD NOVEMBER 3, 1980	MONTH NOV.	DAY 3	YEAR	2d. HOUR 8P.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hawley Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County												
10. CITY OR TOWN OF DEATH Bel Air			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 124 Fairmont Drive						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrical Engineer						12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.							
13a. STATE Maryland			13b. COUNTY Harford Co.		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 124 Fairmont Drive													
14. FATHER'S NAME FIRST John			MIDDLE BENJAMIN		LAST MILLER		15. MOTHER'S MAIDEN NAME ROSE E						16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH seconds									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 191-10-7742						17. INFORMANT (WIFE) 838-2746 ADDRESS Mrs. Dorothy H. Miller 124 Fairmont Drive Bel Air Md. 21014													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:  9554 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.  IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF  (b) DUE TO, OR AS A CONSEQUENCE OF  (c)																						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:00 P.M. 11/3 1980			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home			21f. LOCATION STREET CITY OR TOWN 124 Fairmont Dr. Bel Air Harford Md.						CITY OR TOWN COUNTY STATE										
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																						
ACTUAL SIGNATURE Samuel H. Henck		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER										DATE SIGNED Nov. 3, 1980										
EXAMINER'S NAME (TYPE OR PRINT) Samuel H. Henck, M.D.			ADDRESS 721 WHEELER School Rd., Whitefoot, Md. 21160																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Nov. 5, 1980			23c. NAME OF CEMETERY OR CREMATORIAL GREEN Mount Crematory			23d. LOCATION CITY OR TOWN Baltimore, Maryland			COUNTY			STATE							
24. FUNERAL DIRECTOR Joseph William Foster Superior Funeral			ADDRESS 44 Broadway & Williams St. Bel Air, Maryland 21014			25a. DATE REC'D. BY REGISTRAR NOV 6 1980			25b. REGISTRAR'S SIGNATURE Peter Hall													
BP _____																						
DHMH-17 (VR A15 ME (5)) 15M 7/77																						



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 29022			
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH DAY YEAR		2b. HOUR	
			DAVID WAYNE MULLENS						<input checked="" type="checkbox"/>			11 30 1980		10:15 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR	
male		white		June 30, 1962		18 yrs.				11 30 1980		PM		10:15 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Ohio			U.S.A.						Harford County						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Whiteford			Whiteford Rd. (rt.136)near Deep Run Rd. Mason's Tender			Masonry									
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS						
Maryland			Harford		Bel Air				2849 Forge Hill Road						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
FIRST Louie			MIDDLE E.			LAST Mullens			FIRST Bonnie			MIDDLE LOU		LAST Jones	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No			218-90-2445			Mrs. Bonnie L. Hammons, Bel Air, Md. 21014									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple injuries</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<b>8159</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF															
} (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?									
									<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY <b>9:25 PM</b> MONTH <b>11</b> - <b>30</b> - <b>80</b> P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>occupant of auto/fixed object</b>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>			21f. LOCATION STREET <b>Whiteford Rd.</b> CITY OR TOWN CITY OR TOWN <b>Belair, Maryland</b> COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an death resulted from:			<input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Hormez R. Guard</i>						TITLE (SPECIFY) <b>Assistant</b>			M.D. MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT)			Hormez R. Guard, M.D.			ADDRESS			DATE SIGNED <b>12-1-80</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Dec. 5, 1980</b>			23c. NAME OF CEMETERY OR CREMATORIAL Gdns.			23d. LOCATION CITY OR TOWN <b>Alding</b> COUNTY <b>Harford Co., Maryland</b> STATE						
24 FUNERAL DIRECTOR NAME <b>John H. Harkins</b>			ADDRESS <b>600 Main St., Delta, Pa. 17314</b>			25a. DATE REC'D BY REGISTRAR <b>DEC 8 1980</b>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 29023					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Earl			M.	Norman		11 - 25-1980					1980	6 40 p.m.			
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR				
Male			Negro		OCT 26, 1906			74			IF UNDER 4 HRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN				
99 Havre de Grace			USA					Harford							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Md. Harford			Havre de Grace Hospital					Laborer			Construction				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Md.			Harford		Havre de Grace		YES <input type="checkbox"/> NO <input type="checkbox"/>		415 S. Market Street						
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME									
Unknown						Mollie Norman									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO			218901-5266			George F. Jones Sr. Rising Sun, Md.						3 days			
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, 18c, 18d) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE										?					
0389 Diphilicemia										?					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										DUE TO OR AS A CONSEQUENCE OF C.V.A.					
										DUE TO OR AS A CONSEQUENCE OF A.S.C.V.D.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										2-3 years					
U.T.I.															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from Nov 25, 1980, to Nov 25, 1980, that (I) (we) last saw the deceased alive on Nov 25, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Edward C. Loo, M.D.										DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11/26/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS Havre de Grace, Md. 21078												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 11-30-80			23c. NAME OF CEMETERY, OR CREMATORIAL Pratini & Ferris			23d. LOCATION CITY OR TOWN Westchester Charter Pk			COUNTY SPLITTING			
24. FUNERAL DIRECTOR NAME			25. DATE RECEIVED BY DEPT. OF HEALTH AND MENTAL HYGIENE Paul R. Crouch North East, Md.												

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FILE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 29024						
1- STATE REGISTRAR																		
1. DECEASED NAME (TYPE OR PRINT)		FIRST GAIL			MIDDLE LOUISE			LAST ONKS			2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH 11	DAY 12	YEAR 1980	2b. HOUR 5:15 p.m.		
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH Mar. 10, 1952		YEAR 28	6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. DAYS		7c. DATE PRONOUNCED DEAD		MONTH 11	DAY 12	YEAR 1980	2d. HOUR 5:15 p.m.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lancaster, Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County												
10. CITY OR TOWN OF DEATH Conowingo		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 1, South of Conowingo									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Atomic					
13a. STATE Penns.		13b. COUNTY Chester		13c. CITY OR TOWN Oxford		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Mt. Vernon Road										
14. FATHER'S NAME Earle		MIDDLE --		LAST Wolf		15. MOTHER'S MAIDEN NAME Grace		--		LAST Johnson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 167-44-0092		17. INFORMANT Douglas Woodworth, Oxford, Pa.		ADDRESS												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) Thoracic injury 8120 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.  (b) _____ DUE TO, OR AS A CONSEQUENCE OF  (c) _____ DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <del>XXXX</del> MONTH DAY YEAR 4:20 M 11-12-1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of pick-up truck/auto collision.														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET Rt. 1 so. of Conowingo		CITY OR TOWN Conowingo		COUNTY Harford		STATE Md.								
22a. I certify that I took charge of the remains described above, held on <input checked="" type="checkbox"/> Autopsy, <input type="checkbox"/> Inspection, <input type="checkbox"/> Inquiry, and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																		
ACTUAL SIGNATURE <i>Ann M. Dixon</i>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER									DATE SIGNED 11-13-80							
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St.																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE Nov. 13, 1980		23c. NAME OF CEMETERY OR CREMATORY Woodworth F.H.		23d. LOCATION CITY OR TOWN Oxford		23e. COUNTY Chester		STATE Pa.								
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR NOV 17 1980		25b. REGISTRAR'S SIGNATURE <i>Henry Kelley</i>												
BP																		
DHMH-17 (VR A15 ME (5)) 15M 2/80																		

M

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 29025		
										REG. NO.		
1 - STATE REGISTRAR			1 DECEASED NAME FIRST Joseph PROFFITT LAST PEERY			2a DATE OF DEATH MONTH 11 DAY 2 YEAR 80			2b HOUR 7:50 AM			
3 SEX MALE			4 RACE WHITE			5 DATE OF BIRTH MONTH 10 DAY 10 YEAR 98			6 AGE (IN YEARS LAST BIRTHDAY) 82 (82)			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENN.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			7c BALTIMORE CITY OR COUNTY OF DEATH HARFORD Co. MD.			
10 CITY OR TOWN OF DEATH FALLSTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cert. Public Accountant			12b KIND OF BUSINESS OR INDUSTRY Corporate Tax			
13a STATE Maryland			13b COUNTY Harford Co.			13c CITY OR TOWN Bel Air			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14 FATHER'S NAME FIRST JOHN MIDDLE BROWN LAST PEERY			15 MOTHER'S MAIDEN NAME FIRST MINNIE MIDDLE PROFFITT LAST			16a. STREET ADDRESS 2219 Old Emmorton Road						
16b WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES (W.W.I)			16c SOCIAL SECURITY NO 216-03-6565-A			17 INFORMATION (WIFE) 838-5848 ADDRESS 2219 Old Emmorton Road MRS. LENA C. PEERY Bel Air, Maryland 21014			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10-5-80 11-2-80			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1991 Adenocarcinoma metastatic to Bone Conditions, if any, which gave rise to immediate cause (b) _____ underlying cause (c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from 10-5-80 to 11-2-80, that (I) (we) last saw the deceased alive on 11-1-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE B. PAREKH MD.			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11-2-80			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) B. PAREKH MD.			22f. ADDRESS 1131 Bel Air Road, MD. 21014									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 5, 1980			23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Episc. Ch. Conn.			23d. LOCATION CITY OR TOWN Abingdon, Md. County, Maryland 21009			
24 FUNERAL DIRECTOR Joseph William Foster ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014			25a. REC'D. BY REGISTRAR Nov 6 1980			25b. REGISTRATION NUMBER						

03 8 11

173

100%

100%

(6)

outdoor furniture and chairs

bolt nuts and nuts

1605 aluminum hardware

100%

100%

100% 100% 100%

In 9 pieces no 100% 100% 100%

from hardware store C 337.00 1.20 1.00 1.00 1.00 1.00

100% 100% 100% 100% 100% 100% 100% 100% 100% 100%

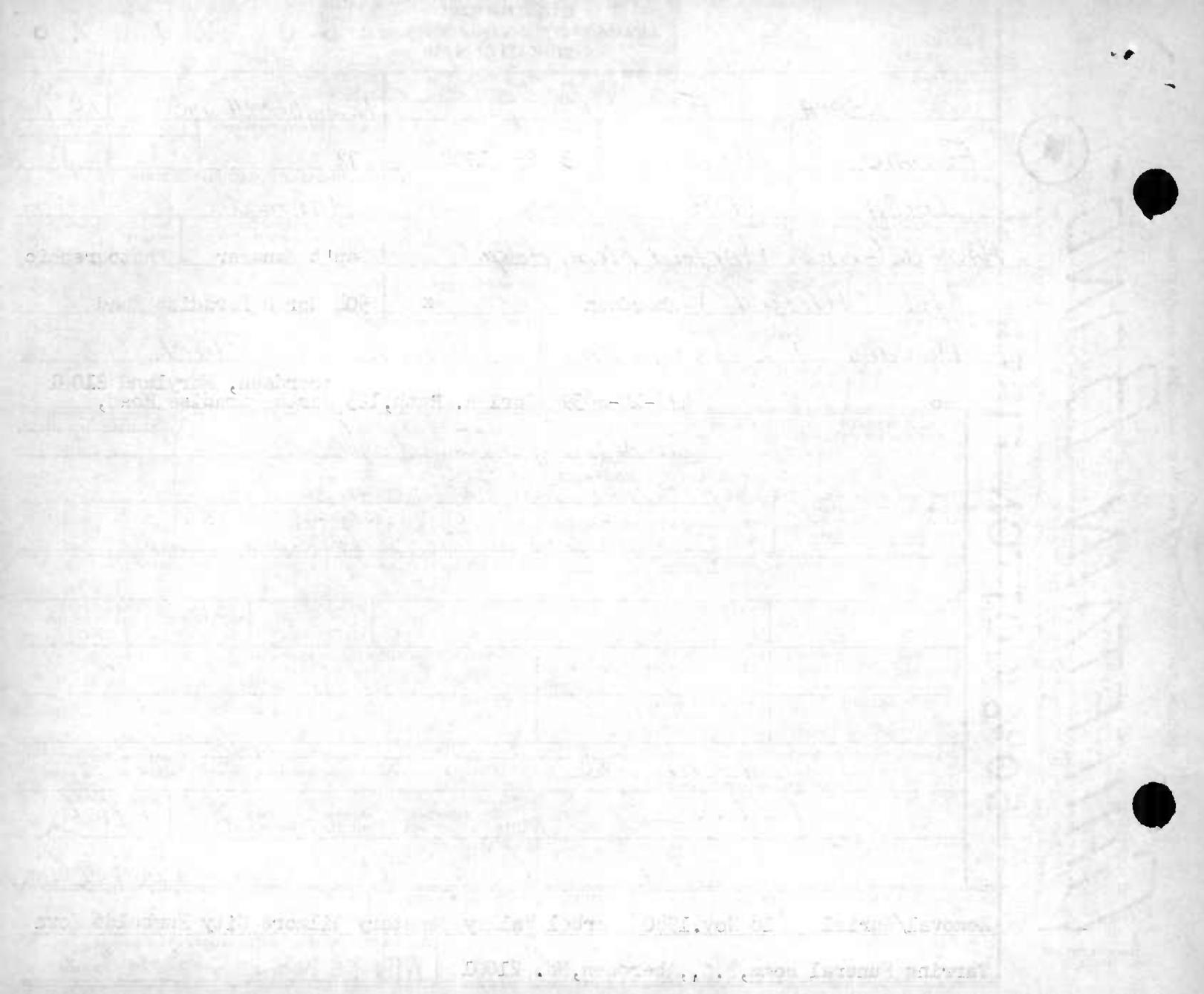
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 29026	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Sara F Phillips						November 14, 1980						10 50 P.M.	
3. SEX			4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female			White	MONTH DAY YEAR			72			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Iowa			USA						Harford				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Harr de Grace			Harford Mem. Hosp.			Dep't Manager			Photographic				
13a. STATE			13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
Md			Harford	Aberdeen		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			504 North Paradise Road				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
Howard C. Ferguson						Minore					Clark		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No			478-10-4839			Carl R. Ruth, 123 North Paradise Road,			Aberdeen, Maryland 21001				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio respiratory failure.</i>													
4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic cardiovascular disease</i> (c) <i>Chronic obstructive pulmonary disease</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>11 - 11, 1980</i> , to <i>11 - 14, 1980</i> , that (I) (we) last saw the deceased alive on <i>11 - 14, 1980</i> , and I hot in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22e. DATE SIGNED	
22b. SIGNATURE <i>J.T. Lee</i>			DEGREE			22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J.T. Lee</i>			22e. ADDRESS <i>Union Medical Clinic, Harr de Grace</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal/Burial			23b. DATE 18 Nov. 1980			23c. NAME OF CEMETERY OR CREMATORIAL Marbel Valley Cemetery			23d. LOCATION CITY OR TOWN Gilmore City Humboldt Iowa			COUNTY	STATE
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001			25a. DATE REC'D. BY REGISTRAR NOV 19 1980			25b. REGISTRAR'S SIGNATURE <i>Lillian McReady</i>							





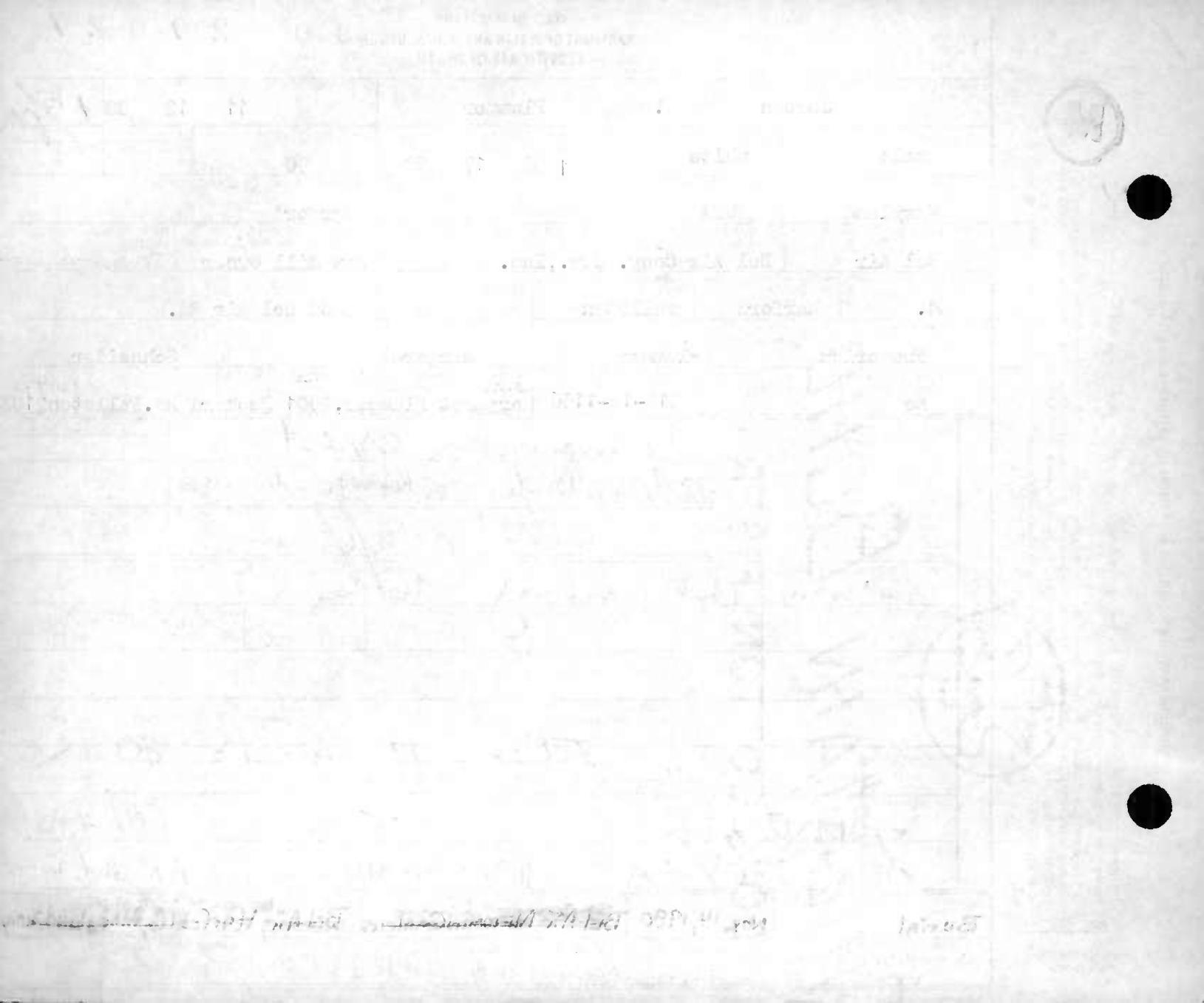
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
retdined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8029027							
												REG. NO.							
1 - FOR STATE REGISTRAR			FIRST			MIDDLE			LAST			2d DATE OF DEATH			MONTH	DAY	YEAR	2d HOUR	
I. DECEASED NAME (TYPE OR PRINT)			Joseph			William			Plummer			11			12	80	115pm		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 2 YEARS				
male			white			MONTH DAY YEAR			90			MONTHS DAYS			HOURS MIN				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
Maryland			USA			10. CITY OR TOWN OF DEATH			Bel Air			Harford			MD.				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY													
Bel Air Conv. Ctr., Inc.			saw mill owner			Timber/Lumber													
13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS							
Md.			Harford			Fallston						3000 Bel Air Rd.							
14 FATHER'S NAME FIRST			MIDDLE			LAST			15 MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST				
Frederick						Plummer			Margaret						Schneider				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17. INFORMANT (NEAREST) ADDRESS S. Adam Plummer													
No			219-14-1156			Margaret Plummer, 2901 Reckord Rd., Fallston 21047													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (21047)							
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)												Cardiopulmonary arrest							
DUE TO, OR AS A CONSEQUENCE (b)												arteriovenous fistula, cardiac dis., w							
DUE TO, OR AS A CONSEQUENCE OF (c)												central injury, brain							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE				
22a. I certify that (I) (this hospital) attended the deceased from Nov. 14, 1980, to Nov. 14, 1980, that (I) (we) last saw the deceased alive on Nov. 14, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 11/14/80							
22b. SIGNATURE <i>Blanchard</i>						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BEN O'BRYZA</i>			22e. ADDRESS 1131 Baltimore Pike, Box AIR, Md. 21014																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 14, 1980			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Bel Air Memorial Gardens Bel Air, Maryland 21014			23d. LOCATION Bel Air, Harford Co., Maryland 21014										
24. FUNERAL DIRECTOR Joseph William Foster			25a. DATE REC'D. BY REGISTRAR NOV 17 1980			25b. REGISTRAR'S SIGNATURE <i>Linda L. Brooks</i>													

4



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 29028						
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI. DEATH MATED			MONTH DAY YEAR	2b. HOUR					
			Grace Leona Riggan						<input checked="" type="checkbox"/> 11 9 80				2347M					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR	2d. HOUR
F		W		10 11 01			79							<input checked="" type="checkbox"/> 11 9 80				2347M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH									
Pennsylvania			U.S.A.			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Harford									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Edgewood			1701-C Fountain Rock-Way			Dietitian			Hotel									
13a. STATE MD			13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1701-C Fountain Rockway									
14. FATHER'S NAME Allen			MIDDLE B.		LAST Watson		15. MOTHER'S MAIDEN NAME Grace		MIDDLE M.			LAST Dibble						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
No			214-12-8356A			Leon T. Benner, 58 Shawgo Ct. 21220												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?												
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																		
ACTUAL SIGNATURE		TITLE (SPECIFY)			M.D. Deputy			MEDICAL EXAMINER			DATE SIGNED 11-10-80							
EXAMINER'S NAME (TYPE OR PRINT)			Luis E. Renjel, M.D.			ADDRESS 464 Alliance St. Havre De Grace, MD												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial Nov. 13, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet			23d. LOCATION CITY OR TOWN Baltimore			COUNTY STATE Md.						
24. FUNERAL DIRECTOR NAME			ADDRESS ROBERT C. ALtenburg FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214			25a. DATE REC'D. BY REGISTRAR NOV 13 1980			25b. REGISTRAR'S SIGNATURE Fayre Kennedy									
BP																		
DHMH - 17 (VR A15 ME (5)) 15M 2/80																		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

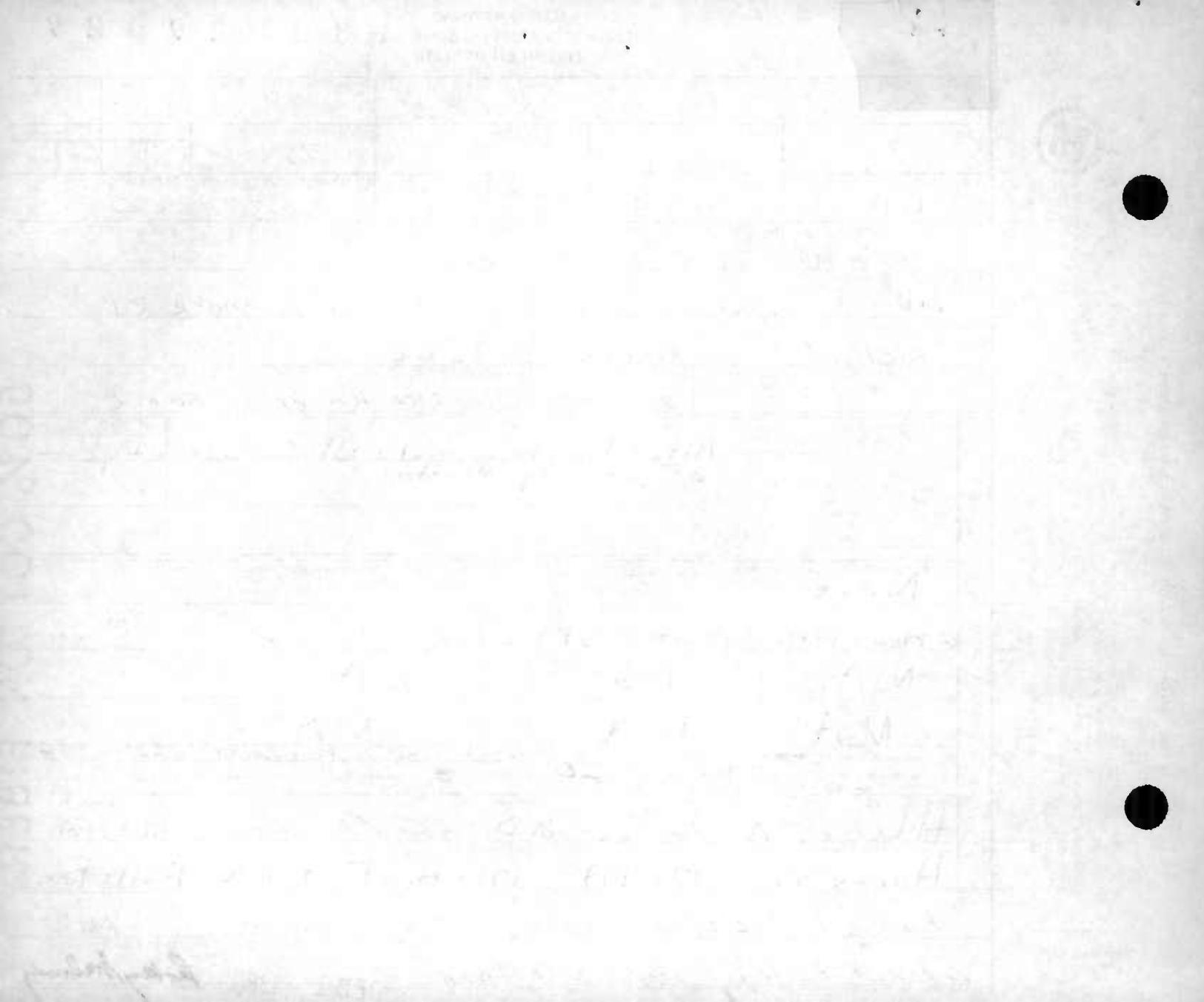
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 8 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					30 29029				
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
John Richard Rogers				11	08	80			
3 SEX	4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				
M	Black	MONTH	DAY	YEAR	76				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH	
MD		U.S.A.						Harpford	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Joppa MD		2105 SINGER Rd.							
13a. STATE		13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS
MD		Joppa							2105 Singer Rd.
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME				
Richard				Rogers	Julie				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS	
(If yes, give war or dates)		216-01-4599			Claurice Rogers same				
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: <u>Metastatic Transitional Cell Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF <u>of urinary bladder</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year
1889 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
October 1, 1980		Obstructing Left kidney			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N.A. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			N.A.	
N.A.									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN N.A.	
		U.S.A.						COUNTY STATE	
22a. I certify that (I) (has) attended the deceased from <u>September 1, 1980</u> to <u>November 29, 1980</u> , that (I) (has) lost saw the deceased alive on <u>October 25, 1980</u> , and that in (my) (his) opinion death occurred on the date and hour and from the causes stated above, (I) (has) (did not) view the body after death.									22c. DATE SIGNED 11-29-80
22d. PHYSICIAN'S NAME (TYPE OR PRINT)									22e. ADDRESS
Harry W. SMITH									1716 Harford Rd. Fallston
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN Baitho		23e. COUNTY Md	
Burial		12/2/80		Western Star					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Vernon R. Bailey		1348 N Calhoun St		DEC 1 1980		Rita Bailey			





**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

29030

**1 - FOR  
STATE  
REGISTRAR**

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR		
<i>Alfonso</i>			<i>SANTORO</i>			<i>10-30</i>	<i>19</i>	<i>50</i>	<i>740</i>			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR		
<i>M</i>	<i>W</i>	<i>10 22 95</i>	<i>85</i>	MONTHS	DAYS	HOURS	MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
<i>- ITALY</i>		<i>U.S.A.</i>					<i>HARFORD</i>					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
<i>Havre de Grace</i>		<i>Harford Memorial</i>			<i>Retiree</i>		<i>SHOE MAKER</i>					
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	14. FATHER'S NAME FIRST MIDDLE LAST					
<i>NY</i>		<i>USA</i>	<i>Brooklyn</i>	YES <input type="checkbox"/> NO <input type="checkbox"/>		<i>4905 11th AV. NY</i>	<i>VINCENZO SANTORO</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
<i>NO</i>		<i>110-01-2613A</i>			<i>VINCENT SANTORO - SAME AS #16</i>		<i>CATERINA ALBANESE</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <i>CORONARY Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause last.  (b) <i>ASCOVD</i> DUE TO, OR AS A CONSEQUENCE OF  (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
					<input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Luis E Renjel</i> TITLE (SPECIFY) <i>M.D. Deputy</i> MEDICAL EXAMINER EXAMINER'S NAME <i>Luis E Renjel MD</i> ADDRESS <i>464 Allaire St Bde Soc Z1022</i>											DATE SIGNED <i>12-1-80</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
<i>BURIAL</i>		<i>DEC 4, 1980</i>		<i>GREENWOOD, Cem.</i>			<i>BROOKLYN</i>				<i>N.Y.</i>	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE RECEIVED BY RELIEF AGENT		25b. PERSON RECEIVING DUTIES		25c. DATE OF RETURN		25d. PERSON RETURNING DUTIES		
<i>R. Madison Mitchell - HAVRE DE GRACE MD.</i>				<i>DEC 4 1980</i>								

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3, RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF INFANT RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DMMH - 17  
[VR A15 ME (S)  
15M 7/77

DHMH-17  
(VR A15 ME (5))  
15M7/77

420

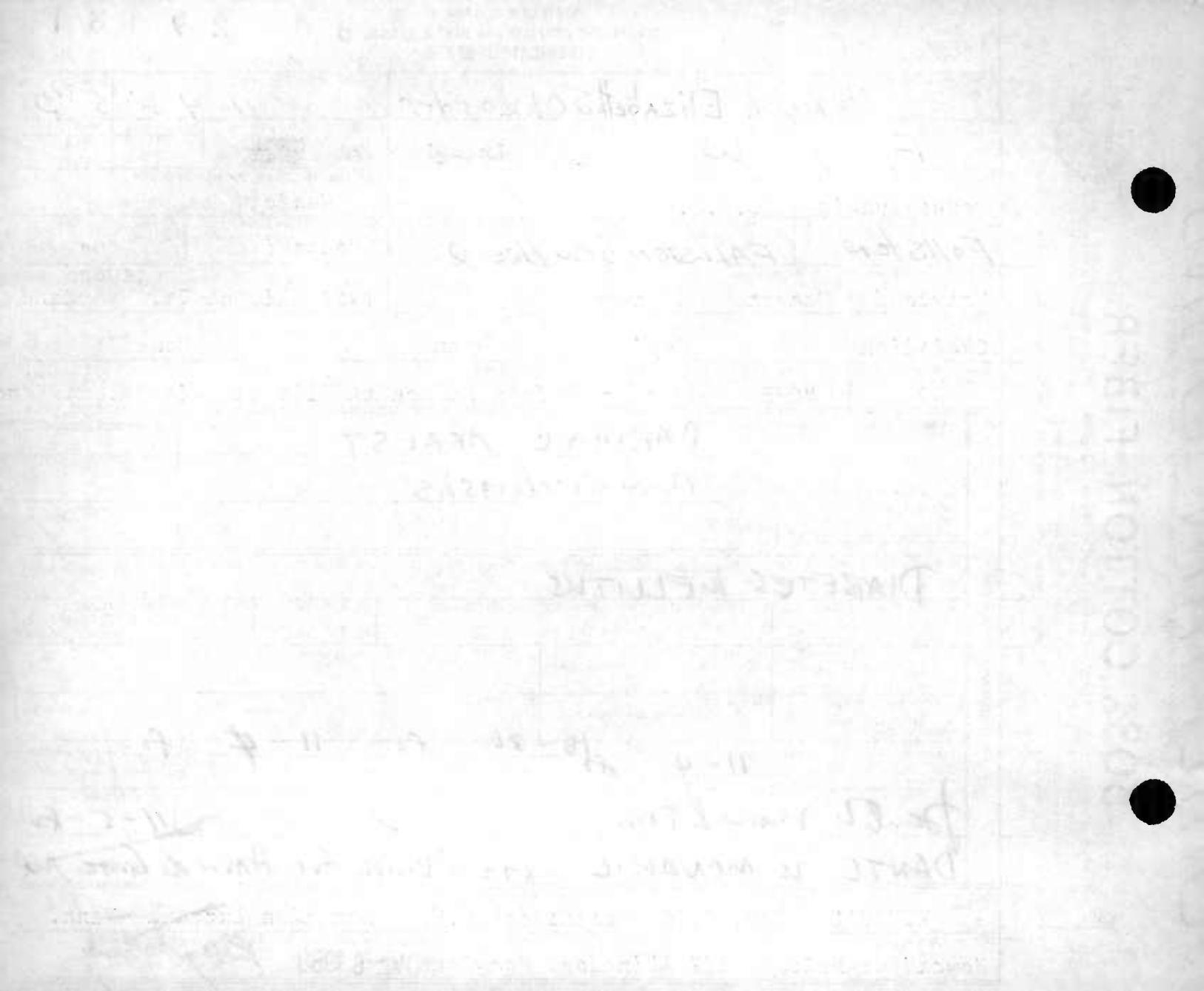
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 29031			
										REG. NO.			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR			
(TYPE OR PRINT)			11 4 80 53 PM							53 PM			
1. DECEASED NAME FIRST MIDDLE LAST			5. DATE OF BIRTH MONTH DAY YEAR							6. AGE (IN YEARS LAST BIRTHDAY)			
Hannah Elizabeth Schroeder			09 12 10							70			
3. SEX F			4. RACE W			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			9. BALTIMORE CITY OR COUNTY OF DEATH Harford				MD.			
10. CITY OR TOWN OF DEATH Fallston			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GEN Hos p.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland			13b. COUNTY Harford			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 1953 Chipper Dr. Maryland			
14. FATHER'S NAME Christian			15. MOTHER'S MAIDEN NAME Hopf			16. SOCIAL SECURITY NO. 189-48-9723				ADDRESS Balti.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. IMMEDIATE CAUSE (a) CARDIAC ARREST			17. INFORMANT John Schroeder				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4409			DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis			18. CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) PART 2. DIABETES MELLITUS							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF (c)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11-4 1980 to 10-30 1980, that (I) (we) lost the deceased alive on 11-4 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			11-4 1980 to 11-4 1980										
22b. SIGNATURE DANTE W. MONAKIL			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 11-5-80					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE W. MONAKIL			22f. ADDRESS 622 S. Union Ave Harde Grange										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL			23b. DATE Nov. 4, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Rosenstock F.H.		23d. LOCATION CITY OR TOWN Hazleton				COUNTY Luzerne	STATE Penn.
24. FUNERAL DIRECTOR NAME Howard K. McComas III			ADDRESS Abingdon, Maryland			25a. DATE REC'D. BY REGISTRAR NOV 6 1980		25b. DEATH TRANSFERTURE Signature					
VRA 15, 4													

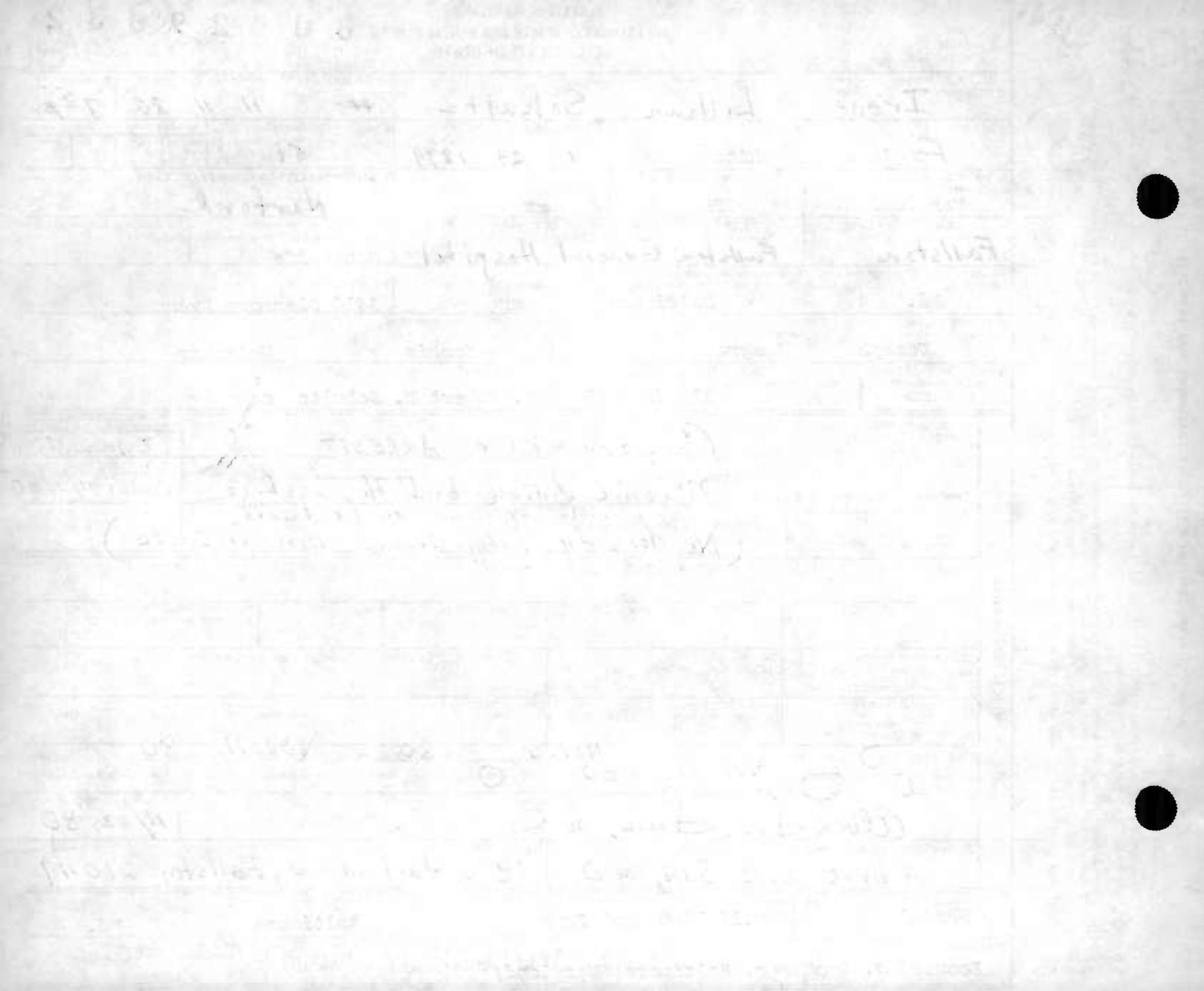


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 &amp; 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 3501 Harford Rd., Baltimore, Maryland.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 80 29032					
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
			Irene Lillian Schultz						# 11 11 80			X 7 55 P.M.					
3 SEX <input checked="" type="checkbox"/> Female			4 RACE <input checked="" type="checkbox"/> White			5 DATE OF BIRTH A MONTH DAY YEAR 1 29 1899			6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
7a BIRTHPLACE STATE OR FOREIGN COUNTRY Maryland			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Harford			MD.					
10 CITY OR TOWN OF DEATH Fallston			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b KIND OF BUSINESS OR INDUSTRY								
13a STATE Md.			13b COUNTY			13c CITY OR TOWN Baltimore			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS 3416 Glenmore Avenue					
14 FATHER'S NAME FIRST MIDDLE LAST Joseph League			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie Weissner														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b SOCIAL SECURITY NO 215-42-9847			17 INFORMANT Mr. Robert E. Schultz same											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 minutes		
4310 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Massive Intracerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF <u>with extension to Ventricles</u> <u>(No clear P.H. of Hypertension, DM, MI, etc.)</u>															onset 11/3/80		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that (1) (this hospital) attended the deceased from <u>Nov. 6, 1980</u> to <u>Nov. 11, 1980</u> , that (2) (we) last saw the deceased alive on <u>Nov. 11, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Albert S.C. Sun, M.D.</u>			DEGREE			22c. DATE SIGNED 11/12/80											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert S.C. Sun, M.D.			22e ADDRESS 1800 Harford Rd., Fallston 21047														
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE Nov. 15, 1980			23c NAME OF CEMETERY OR CREMATORIAL Oak Lawn			23d LOCATION CITY OR TOWN Baltimore			COUNTY			STATE Md.		
24 FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland			ADDRESS			25a. DATE REC'D. BY REGISTRAR NOV 12 1980			25b. REGISTRAR'S SIGNATURE <u>Henry Kerney</u>								

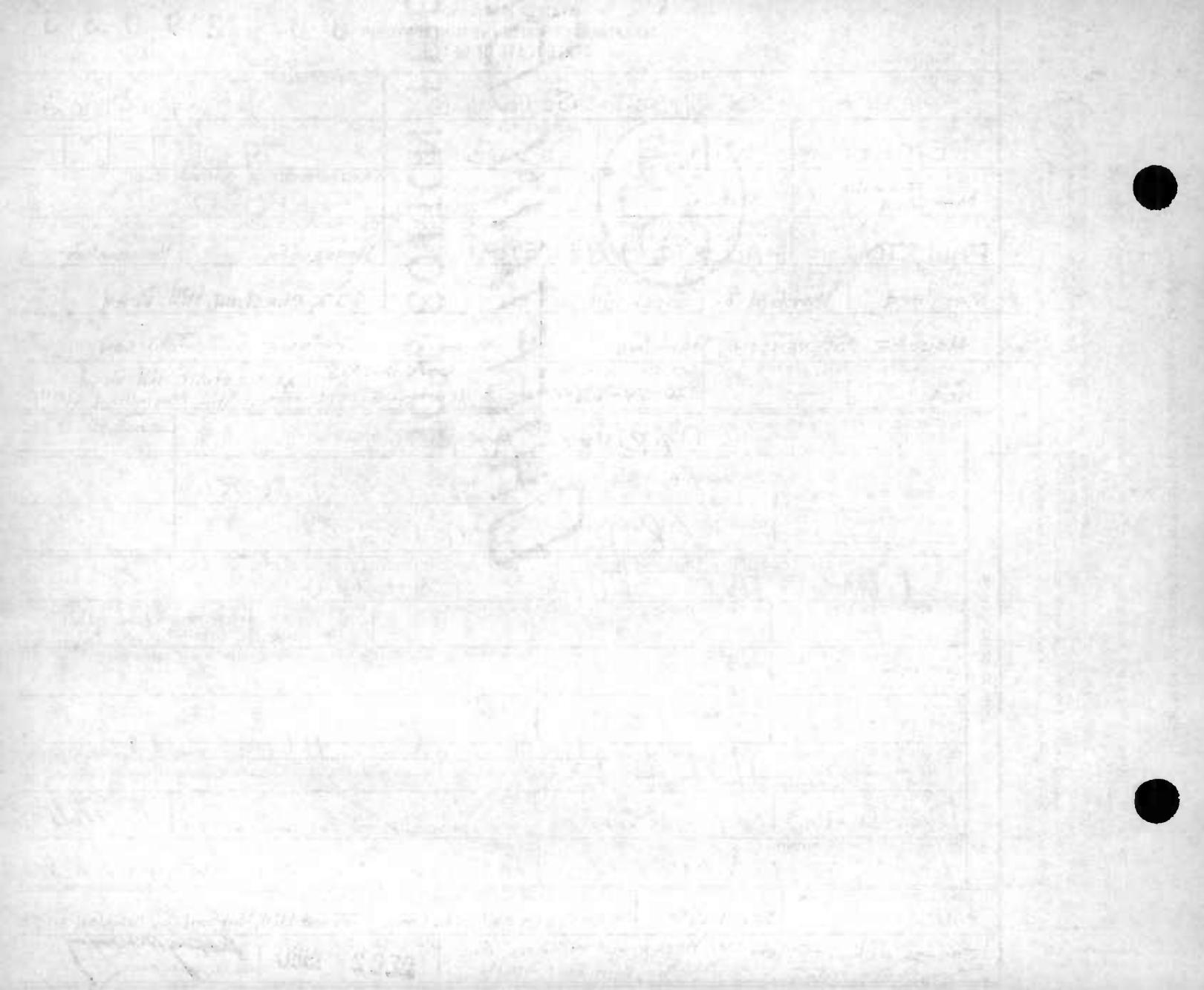


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 29033	
										REG. NO.	
1. FOR STATE REGISTRAR		I. DECEASED NAME FIRST MIDDLE LAST				2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
		NORA CORRINE SEIBOLD				11-29-80			6 A.M.		11
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		WHITE		MONTH DAY YEAR 12 - 25 - 00		79 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Forest Hill Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.					
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOMEMAKER					
13a. STATE Maryland		13b. COUNTY Harford Co.		13c. CITY OR TOWN Forest Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 622 Chestnut Hill Road			
14. FATHER'S NAME FIRST MIDDLE LAST MAURICE STEVENSON HARKINS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary CORINNE Johnson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-54-9676-T		17. INFORMANT (SON) 838-6815 ADDRESS Mr. Gordon L. Seibold 622 Chestnut Hill Road Forest Hill, Maryland 21014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ARTERY DISEASE (c) ARTERIOSCLEROSIS											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CONGESTIVE HEART FAILURE											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 11/18/80 to 11/29/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dante N. Monakil		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/29/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE N. MONAKIL		22e. ADDRESS Fallston Gen Hosp. Fallston, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE DEC. 1, 1980		23c. NAME OF CEMETERY OR CREMATORIAL DEET GREEK METHOD. CH. CEM.		23d. LOCATION CITY OR TOWN Forest Hill, Harford Co., Maryland 21050		COUNTY STATE			
24. FUNERAL DIRECTOR Joseph William Fester ADDRESS Bel Air, Maryland 21014		25a. DATE REC'D. BY REGISTRAR DEC 2 1980				25b. SIGNATURE					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 29034	
												REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			<i>RUTHANN L. Smith</i>						Nov. 6 1980			8:00 P.M.	
3. SEX			4. DATE OF BIRTH MONTH DAY YEAR			5. AGE (IN YEARS LAST BIRTHDAY) 85			6. IF UNDER 1 YEAR MONTHS DAYS			7. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>HARFORD</i>			MD.	
10. CITY OR TOWN OF DEATH <i>HARFORD</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>HARFORD MEMORIAL HOSPITAL</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOME MAKER</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>				
13a. STATE <i>MD</i>			13b. COUNTY <i>HARFORD</i>			13c. CITY OR TOWN <i>HARFORD</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <i>413 N. Stokes, St.</i>	
14. FATHER'S NAME FIRST <i>REGEN</i>			MIDDLE <i>-</i>			LAST <i>LOWE</i>			15. MOTHER'S MAIDEN NAME FIRST <i>JOYCE</i>			LAST <i>CRAIG</i>	
16a. DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>214-70-1735</i>			17. INFORMANT <i>Mrs. DOROTHY V. ESTES, PERRYVILLE MD</i>			ADDRESS <i>53 PATERSON, AVE.</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4292</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic cardiovascular d</i> DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>10 - 28</i> , 19 <i>80</i> , to <i>11 - 6</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>11 - 6</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>J. T. Lee</i>			22c. DEGREE <i>MD</i>			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>11/80</i>				
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. T. Lee</i>			22g. ADDRESS <i>Union Med Clinic, HARFORD</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>Nov. 10, 1980</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>ANGELILL CEM. HAVREDE GRACE</i>			23d. LOCATION CITY OR TOWN <i>HARFORD</i>			STATE <i>MARYLAND</i>	
24. FUNERAL DIRECTOR <i>R. Madeline Mitchell, HAVREDE GRACE</i>			25. ADDRESS <i>Mo. NOV 12 1980</i>			25a. DATE REC'D. FOR REGISTRATION <i>NOV 12 1980</i>			25b. SIGNATURE <i>R. Madeline Mitchell, HAVREDE GRACE</i>				

100-1007

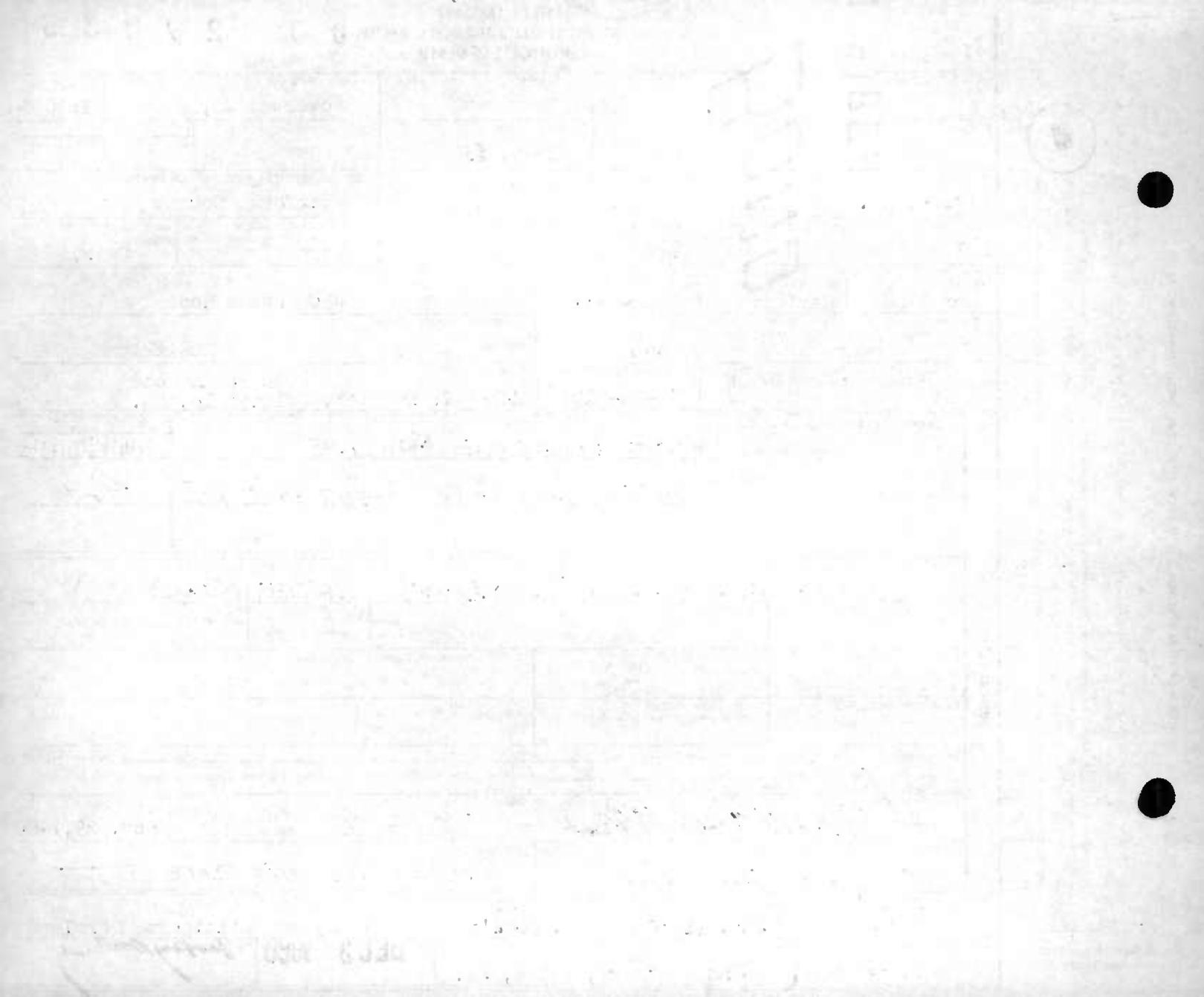


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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8029035				
1 - FOR STATE REGISTRAR			2d. DATE OF DEATH MONTH DAY YEAR November 28, 1980									2b. HOUR 1:30 P.M.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST JOHN E.			MIDDLE TAHANEY			LAST							
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH July DAY 9, 1893 YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 87			IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0		IF UNDER 24 HRS		
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Benson, Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.							
10. CITY OR TOWN OF DEATH Pylesville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4900 Rocks Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Dairy							
13a. STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Pylesville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 4900 Rocks Road				
14. FATHER'S NAME FIRST John			MIDDLE			LAST Tahaney			15. MOTHER'S MAIDEN NAME FIRST Mary			MIDDLE			LAST McGilligan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-28-6131			17. INFORMANT ADDRESS 4900 Rocks Road			Mabel K. Tahaney, Pylesville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 ACUTE CONGESTIVE FAILURE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) ARTERIOSCLEROTIC HEART DISEASE 1969													
			(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CHRONIC BRAIN SYNDROME - ARTERIOSCLEROSIS -																
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did/did not view the body after death.																
22b. SIGNATURE <i>H. Martello MD</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED Nov. 29, 1980							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Herbert A. Martello M.D.			22e. ADDRESS WHITEFORD MD. 21160													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 2, 1980			23c. NAME OF CEMETERY OR CREMATORIAL St. John's			23d. LOCATION CITY OR TOWN Hydes			COUNTY Baltimore		STATE Maryland		
24. FUNERAL DIRECTOR NAME John H. Harkins, 600 Main Street, Delta, Pa.			ADDRESS			25a. DATE RECEIVED BY REGISTRAR DEC 3 1980			25b. RECEIVED BY CLERK							

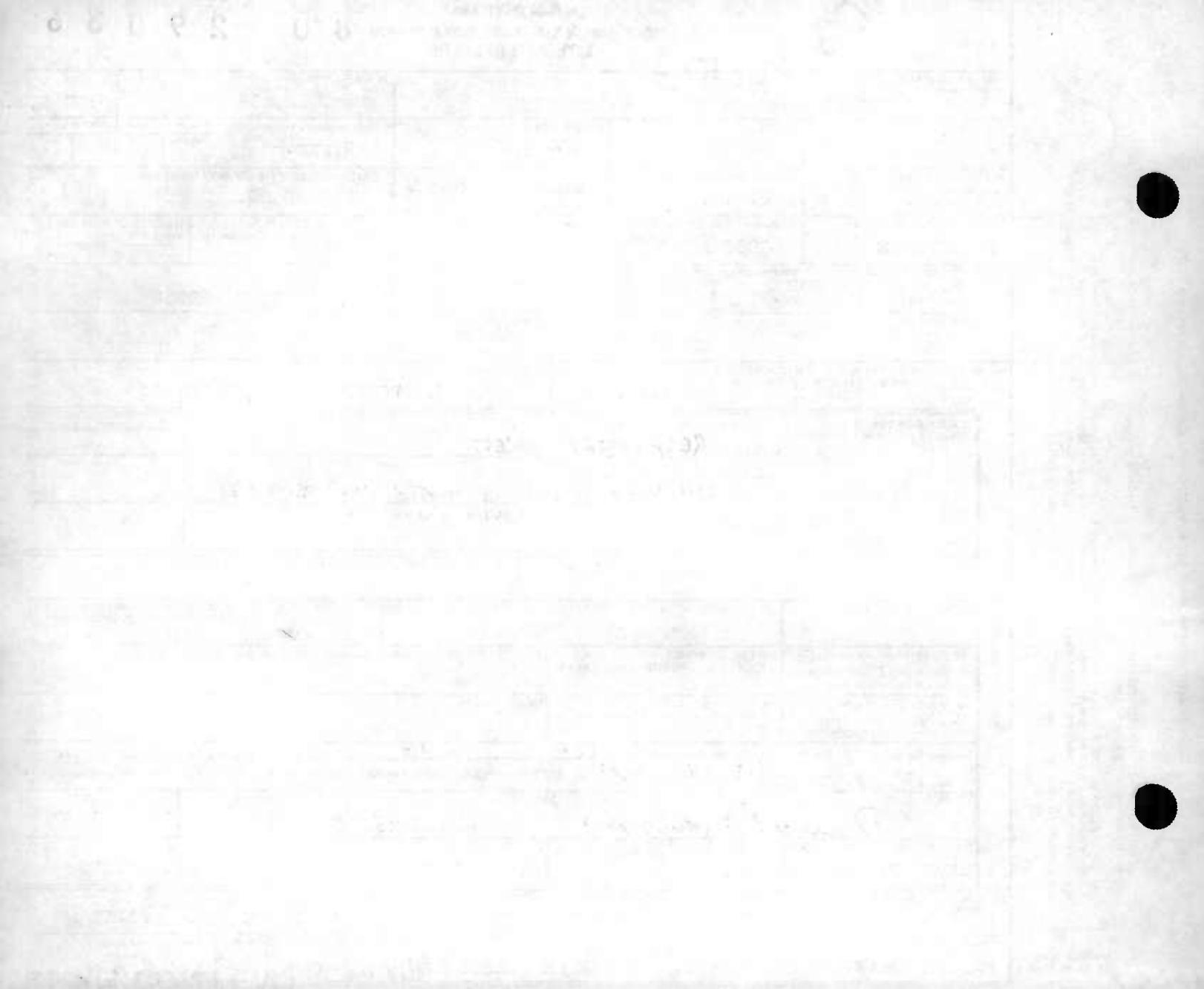


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be sealed for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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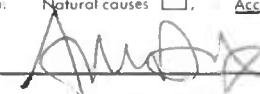
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 29036				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
JOSEPH			ALLEN		THOMPSON	Nov. 16, 1980						5:00 A.M.				
3. SEX		4 RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
MALE		WHITE		MONTH 8/3/1898 DAY YEAR			82 yrs.			MONTHS	DAYS	HOURS	MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
MARYLAND		U.S.A.					HARFORD CO.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
PYLESVILLE		3950 ADY ROAD			FOREMAN			STEEL MFGR.								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																
13a. STATE MARYLAND		13b. COUNTY BALTO.		13c. CITY OR TOWN DUNDALK			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS 2484 KEYWAY 21222							
YES <input checked="" type="checkbox"/>		NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
14. FATHER'S NAME FIRST DAVID		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST ELLA			MIDDLE		LAST DEEMS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		(IF YES, GIVE WAR OR DATES) WW I		16b. SOCIAL SECURITY NO 217.01.2824			17. INFORMANT BESSIE M. THOMPSON			ADDRESS --SAME AS 13e						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<b>7991</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																
(b) <b>ADVANCED SENILE DEMENTIA AND DECREASED CRANIAL FUNCTION</b>																
(c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from Oct 19 26 to 19 , that (I) (we) last saw the deceased alive on Oct 24 19 20 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death												22c. DATE SIGNED 11/17/1980				
22b. SIGNATURE <i>David P. Zajano MD</i>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID P. ZAJANO, M.D.		22e. ADDRESS 6800 MORNINGTON RD., DUNDALK MD. 21222														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11/19/1980		23c. NAME OF CEMETERY OR CREMATORIAL OAK LAWN CEMETERY			23d. LOCATION CITY OR TOWN BALTIMORE		COUNTY	STATE MARYLAND						
24. FUNERAL DIRECTOR NAME WALTER BROOKS BRADLEY INC., DUNDALK MD 21222		ADDRESS			25a. DATE REC'D. BY REGISTRAR NOV 20 1980			25b. REGISTRAR'S SIGNATURE <i>Lester Brooks</i>								

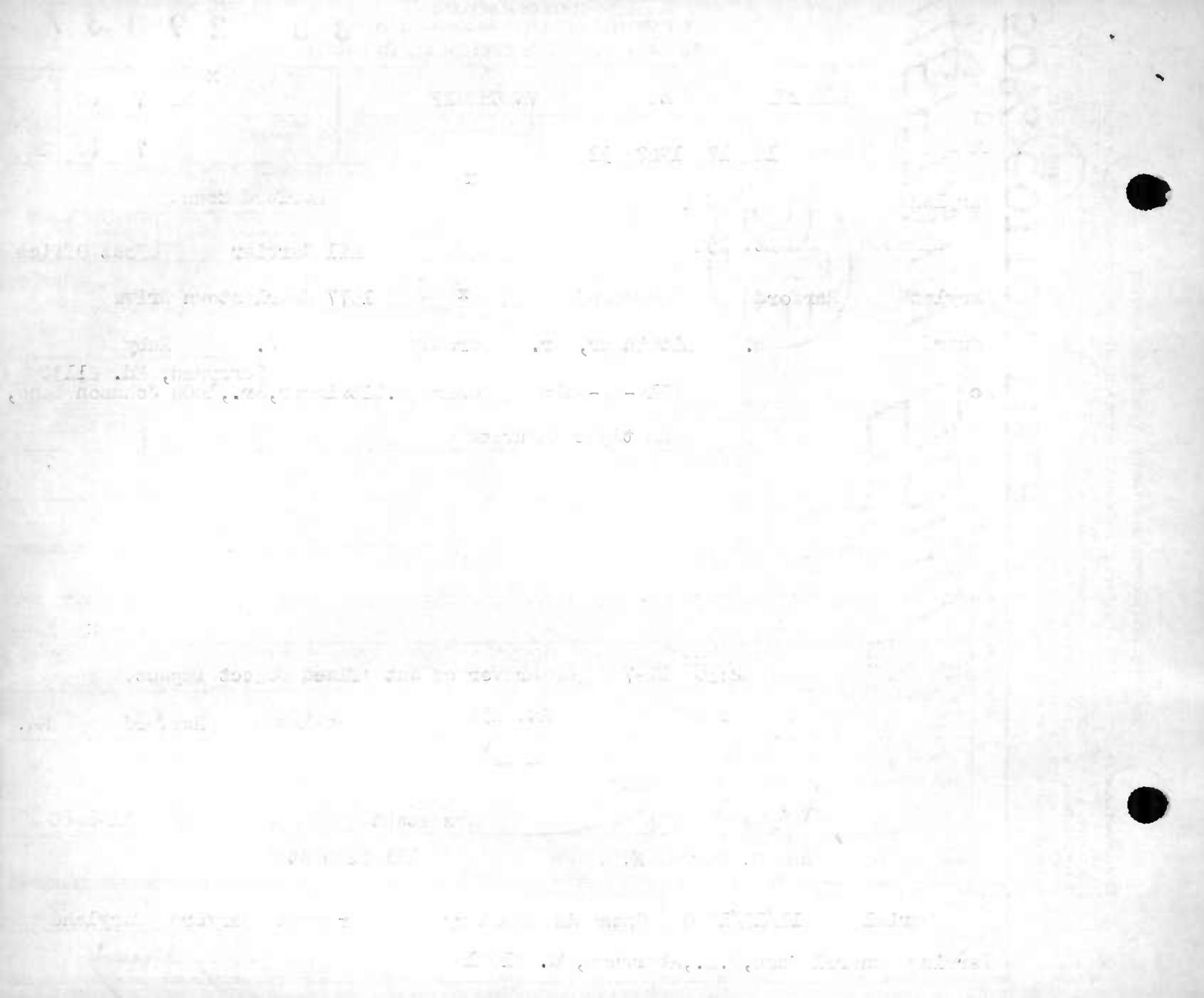


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 IN YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 29037		
1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>DOROTHY</b>	MIDDLE <b>A.</b>	LAST <b>VANCHERIE</b>	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH <input checked="" type="checkbox"/> 11	DAY <input type="checkbox"/> 7	YEAR <input type="checkbox"/> 1980	2b. HOUR <input type="checkbox"/> M		
3. SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH <b>12</b>	DAY <b>17</b>	YEAR <b>1947</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>32</b> YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/>	IF UNDER 24 HRS. DAYS <input type="checkbox"/>	HOURS <input type="checkbox"/>	MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD	MONTH <input type="checkbox"/> 11	DAY <input type="checkbox"/> 7	YEAR <input type="checkbox"/> 1980	2d. HOUR <input type="checkbox"/> 2a M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford County</b>						
10. CITY OR TOWN OF DEATH <b>Fallston</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rt. 152</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mail Carrier</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Post Office</b>			
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Edgewood</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET ADDRESS <b>1577 Charlestown Drive</b>								
14. FATHER'S NAME FIRST <b>Edward</b>			MIDDLE <b>D.</b>	LAST <b>Litzinger, Sr.</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Dorothy</b>			MIDDLE <b>V.</b>	LAST <b>Ruby</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>219-44-9406</b>			17. INFORMANT ADDRESS <b>Perryman, Md. 21130</b>			Edward D. Litzinger, Sr., 1604 Johnson Lane,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple injuries</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<b>8150</b> Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> } DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <b>xx</b> MONTH <b>11</b> DAY <b>7</b> YEAR <b>1980</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Driver of auto/fixed object impact.</b>			<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, STORE, FARM, ETC.) <b>Road</b>			21f. LOCATION Rt. <b>152</b>			CITY OR TOWN <b>Fallston</b>	COUNTY <b>Harford</b>	STATE <b>Md.</b>			
22a. I certify that I took charge of the remains described above, held an <b>Autopsy</b> <input checked="" type="checkbox"/> , <b>Inspection</b> <input type="checkbox"/> , <b>Inquiry</b> <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input type="checkbox"/> , <b>Accident</b> <input checked="" type="checkbox"/> , <b>Suicide</b> <input type="checkbox"/> , <b>Homicide</b> <input type="checkbox"/> , <b>Undetermined manner</b> <input type="checkbox"/>														
ACTUAL SIGNATURE  TITLE (SPECIFY) <b>Assistant M.D.</b> MEDICAL EXAMINER EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b> ADDRESS <b>111 Penn St.</b>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11/13/1980</b>			23c. NAME OF CEMETERY OR CREMATORIUM <b>Spesutia Cemetery</b>			23d. LOCATION CITY/TOWNSHIP <b>Perryman</b>			COUNTY <b>Harford</b>	STATE <b>Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Tarring Funeral Home, P.A., Aberdeen, Md. 21001</b>			ADDRESS <b>21001</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1980</b>			25b. REGISTRAR'S SIGNATURE <b>Larry McElroy</b>					
DHMH - 17 (VR A15 ME (5)) 15M 2/80														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 80 29038			
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR November 15 1980							2b. HOUR 4:25 P.M.			
1. DECEASED NAME FIRST MIDDLE LAST RUSSELL Otha Wilgis			5. DATE OF BIRTH MONTH DAY YEAR Oct 5, 1897			6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN				
3. SEX MALE		4. RACE White		8. CITIZEN OF WHAT COUNTRY? U.S.A.			9. BALTIMORE CITY OR COUNTY OF DEATH Hartford County			MD.			
10. CITY OR TOWN OF DEATH Bel Air			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 127 churchville road			12e. USUAL OCCUPATION SALESMAN			12d. KIND OF BUSINESS OR INDUSTRY GASOLINE				
13a. STATE Maryland			13b. COUNTY Harford Co.		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1927 churchville road				
14. FATHER'S NAME FIRST Elijah MIDDLE Roger LAST Wilgis			15. MOTHER'S MAIDEN NAME FIRST Ida MIDDLE LAST JEFFERY										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES - Army			16b. SOCIAL SECURITY NO. W.W. 1 215-03-2954			17. INFORMANT (Dwight E. Mrs. Zelma A. Sheridan)			ADDRESS 1 Fairfield Rd., Rolling Park Clayton, Del. 19703				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma, left upper lobe A</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Lung</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>March 29, 1980</u> to <u>Nov. 15, 1980</u> , that (I) <u>did</u> last saw the deceased alive on <u>Nov. 6, 1980</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> <u>not</u> view the body after death.													
22b. SIGNATURE <u>BEN OTEYZA</u>		DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>Nov 15, 1980</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BEN OTEYZA, M.D.</u>		22e. ADDRESS <u>1131 Baltimore Pike, Bel Air, Md. 21014</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Nov. 18, 1980</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>Bel Air Memorial Gardens</u>			23d. LOCATION CITY OR TOWN <u>Bel Air, Harford Co., Maryland</u> STATE <u>21014</u>					
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>		ADDRESS <u>W. Broadway &amp; Williams St.</u>			25a. DATE REC'D. BY REGISTRAR <u>NOV 20 1980</u>			25b. REGISTRAR'S SIGNATURE <u>Joseph William Foster</u>					
		<u>Sykesville, Md.</u>											

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12/18/80

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED. WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

29039

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
Madeline Williams							<input type="checkbox"/>	11	26	80	3p M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH					
F	B	5 5 98	82 yrs.	USA		Harford					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Havre De Grace		1402 Ontario St.				Housewife					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS							
MD	Harford	Havre De Grace	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	1402 Ontario St.							
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST				ADDRESS				
Malachi		Harris	Estella Jones 4440 personal papers				Gravel Hill HDG				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No											
16b. SOCIAL SECURITY NO. 800-19-5720											
17. INFORMANT ADDRESS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 4149 Candidias, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. } DUE TO, OR AS A CONSEQUENCE OF ASCVD (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		TITLE (SPECIFY) Deputy M.D.				MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)		Luis E. Renjel, M.D.				DATE SIGNED 11-26-80					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 12-2-80		23c. NAME OF CEMETERY OR CREMATORIAL ST. James		23d. LOCATION CITY OR TOWN Havre De Grace, Harford		COUNTY Md		STATE	
24. FUNERAL DIRECTOR NAME		ADDRESS Arnold Boards 117 Cec. 1 Ave		25a. DATE REC'D. BY REGISTRAR NOV 28 1980		25b. REGISTRAR'S SIGNATURE Peter Balon					
DHMH-17 (VRA15 ME (5)) 15M 2/80											

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8029040

REG. NO.

1 - STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)					FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
Bertha Catherine Wilson								11-15-	80			11-15 am		
3. SEX		4 RACE		5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		MONTH 01	DAY 10	YEAR 88	92			MONTHS YRS	DAYS	HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH							
M.D.		USA					Harford County							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Havre-De-Grace		Citizens Nursing Home		Housewife										
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS							
Maryland		Harford		Fallston			2705 Lakeland Drive							
14 FATHER'S NAME		FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST				
Henry Jackson					Grace A. Van Horn									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT			ADDRESS			21047				
No		320-05-2697		Beverly Willis 2705 Lakeland Drive, Fallston										
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <i>Pulmonary Failure</i>														
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma, Lung</i>		
{ DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>ARTERIOSCLEROTIC HEART DISEASE</i>														
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a I certify that (I) (this hospital) attended the deceased from		12-14-79		to 11-15-80										
saw the deceased alive on		19		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE			ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED	
Dante N. Monakil, MD.													11/16/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS												
DANTE N. MONAKIL, MD.		Harde Grac, Md 21078												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		Nov 18, 80		Jessups Meth Cem			Cockeysville, Md.							
24 FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REG'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Dippel Funeral Homes, Inc.		Balto., Md 21206 7110 Belair Rd.		NOV 24 1980										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examining must be notified at once.

M

cont'd

every business trip

strafing strafing

new route

Heavy legroom

every flight 300 passengers arrive

initial 80 passengers per flight

per flight

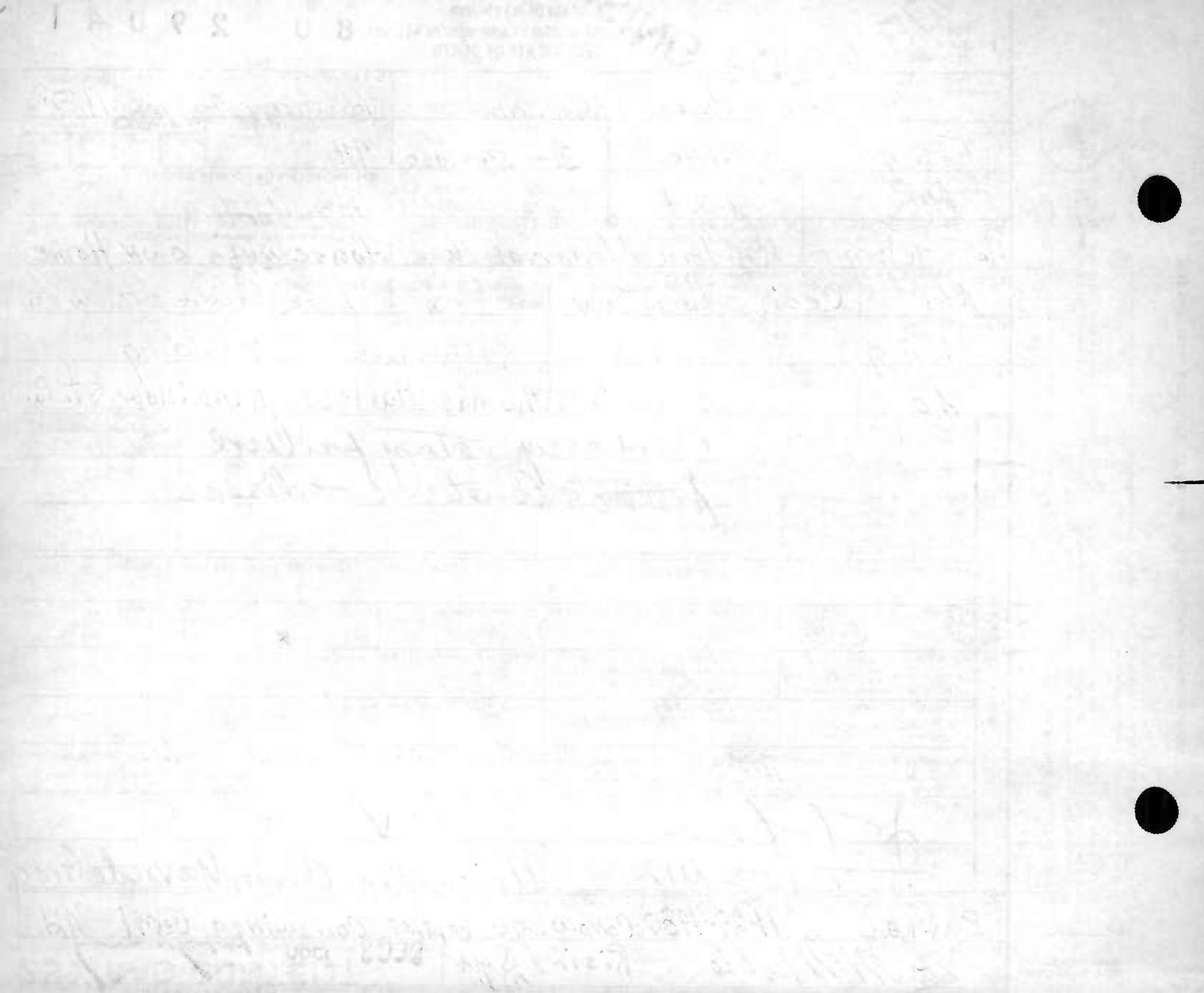
initial 80 passengers per flight

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours at the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examining/physician must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8029041	
												REG. NO.	
1 - STATE REGISTRAR			1a DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR	
			Chessie Pearl Wilson						November 26 1980			11:20 PM	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female			White			3-23-1906			74 YRS.				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.	
N.C.			U.S.A.						Harford				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Harford Grace			Harford Memorial Hosp.			Housewife own home							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS	
Md			Cecil			Rising Sun			No			Box 136 Woodie Brown Rd	
14 FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Henry Teague			Katherine Spaulding										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (# YES, GIVE WAR OR DATES)			16b SOCIAL SECURITY NO			17 INFORMANT			18 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			915-28-7677			Thomas Harless			R.D. Willow St. P.A.				
18 CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory failure</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterial occlusive disease</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a MEDICAL CERTIFICATION			19b DATE OF OPERATION			19c CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>11-18</u> , 19 <u>80</u> , to <u>11-26</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11-26</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>J. T. Lee</u>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. T. Lee MD.</u>			22f. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)			23b. DATE 11-29-1980			23c. NAME OF CEMETERY OR CREMATORIAL Coronwingo Baptist			23d. LOCATION CITY OR TOWN Coronwingo Cecil Md.			23e. COUNTY Cecil	
24. FUNERAL DIRECTOR NAME <u>E. McMullen</u>			ADDRESS Rising Sun Md.			25a. DATE REC'D. BY REGISTRAR Dec 9 1980			25b. REGISTRAR'S SIGNATURE				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 29042		
												REG. NO.		
1 - STATE REGISTRAR	(EVELYN GIER WILSON)													
1 DECEASED NAME (TYPE OR PRINT)	FIRST (EVELYN)		MIDDLE (GIER)	LAST (WILSON)			2a. DATE OF DEATH (Nov. 1, 1980)			MONTH NOV	DAY 1	YEAR 80	2b. HOUR 2:48 A.M.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH (July 4, 1905) MONTH 07 DAY 04 YEAR 05			6 AGE IN YEARS LAST BIRTHDAY (75)			IF UNDER 1 YEAR MONTHS 75 YRS.		# UNDER 24 HRS HOURS 2 MIN 48		
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Harford County, MD.						
10 CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Education						
13a. STATE Maryland		13b. COUNTY Harford Co.		13c. CITY OR TOWN Forest Hill			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS (P.O. Box #36) 54 East JAMESTOWN Road				
14 FATHER'S NAME HENDERSON		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Haddie			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-38-2378-A			17. INFORMANT (Husband) 838-3036 Mr. Paul F. Wilson			ADDRESS P.O. Box 36 Forest Hill, Maryland 21050						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE CARDIAC FAILURE												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS		
7101 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ACUTE RENAL FAILURE (c) MIXED LONGEVITOUS TISSUE DISEASE / SCHWEDERTA- PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4 7 years														
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from OCT 8, 1980, to NOV 1, 1980, that (I) (we) last saw the deceased alive on NOV 1, 1980, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE A.J. Aeas		22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED NOV 1, 1980						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) A. SWEATMAN M.D.		22f. ADDRESS Fallston Gen. Hospital												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 3, 1980		23c. NAME OF CEMETERY OR CREMATORIAL DEET Creek Meth. Cem.			23d. LOCATION CITY OR TOWN Forest Hill, Harford Co., Maryland 21050			COUNTY	STATE			
24. FUNERAL DIRECTOR Joseph William Foster ADDRESS Bel Air, Maryland 21014		25a. DATE REC'D. BY REGISTRAR NOV 5, 1980			25b. REGISTRAR'S SIGNATURE Linton McCreedy									

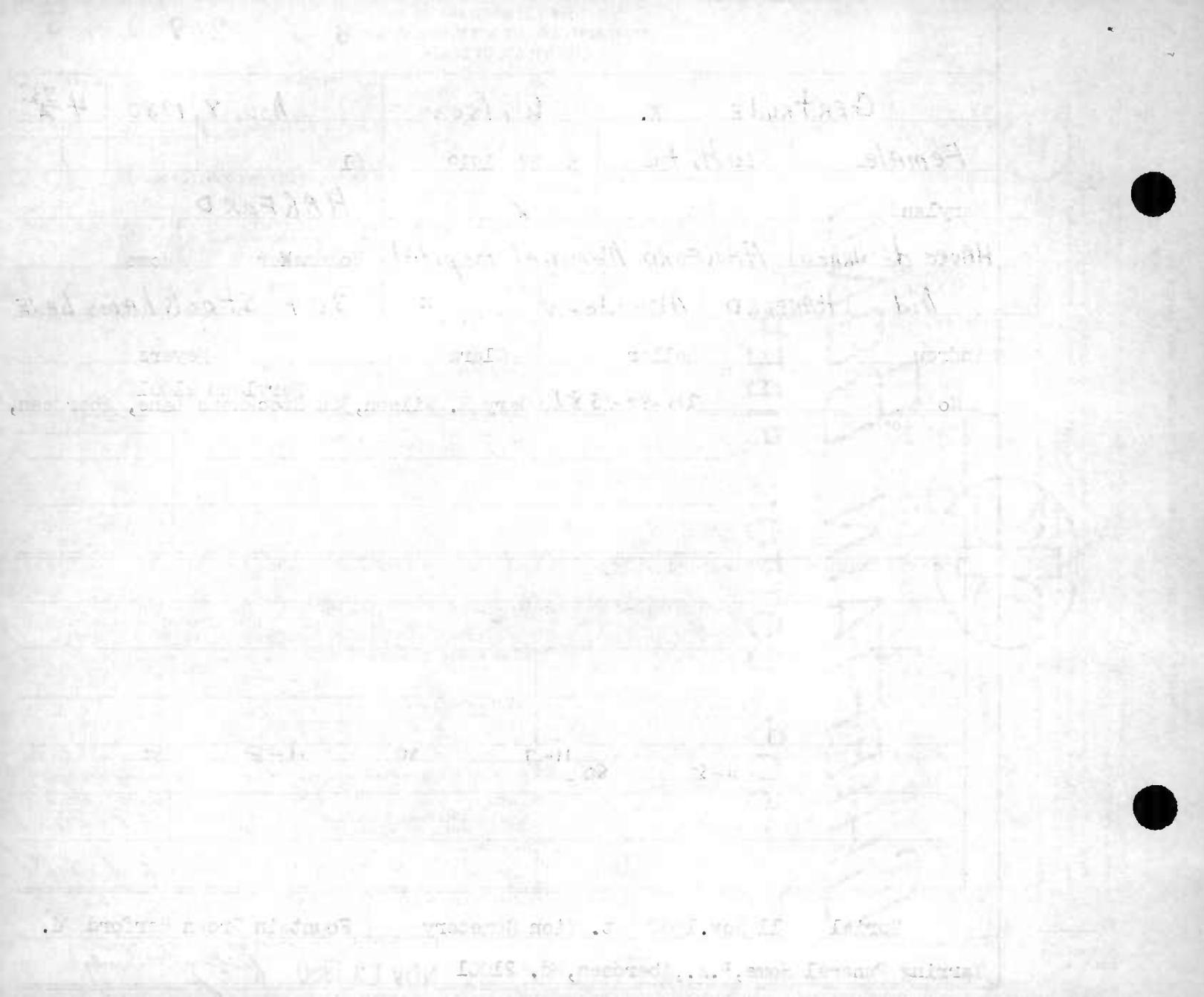


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 9 0 4 3 CERTIFICATE OF DEATH												
REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	
<i>GERTRUDE K. Wilson</i>						<i>Nov. 8, 1980</i>						
3. SEX			4. RACE		S. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		2b. HOUR	
<i>Female</i>			<i>white</i>		<i>5 27 1919</i>	<i>61</i>			<input type="checkbox"/> MONTHS	<input type="checkbox"/> DAYS	<i>4 33 A.M.</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
<i>Maryland</i>			<i>USA</i>					<i>HARFORD</i>				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
<i>Hause de Grace</i>			<i>HARFORD Memorial Hospital</i>			<i>Homemaker</i>			<i>Home</i>			
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
<i>Md.</i>			<i>HARFORD</i>	<i>Aberdeen</i>				<i>304 Stockhams Lane</i>				
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST			
<i>Andrew</i>				<i>Keller</i>	<i>Clara</i>					<i>Meyers</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR OATES)			17. INFORMANT			ADDRESS			
<i>No</i>			<i>215-94-1381</i>			<i>Gary R. Wilson, 304 Stockhams Lane, Aberdeen,</i>			<i>Maryland 21001</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of Right lung with metastasis</i>												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>approx 3 months</i>												
16b. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>11-7</i> , 19 <i>80</i> , to <i>11-8</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>11-8</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>M. Murphy</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>11-8-80</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>McNamee, JESADA</i>			22e. ADDRESS <i>615 S. Union Ave. Harford Md. 21028</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <i>Burial 11 Nov. 1980</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Zion Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Fountain Green Harford Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Tarring Funeral Home, P.A., Aberdeen, Md. 21001</i>			ADDRESS			25a. DATE REC'D. BY REGISTRAR <i>NOV 13 1980</i>			25b. REGISTRAR'S SIGNATURE <i>Lisiting McNamee</i>			



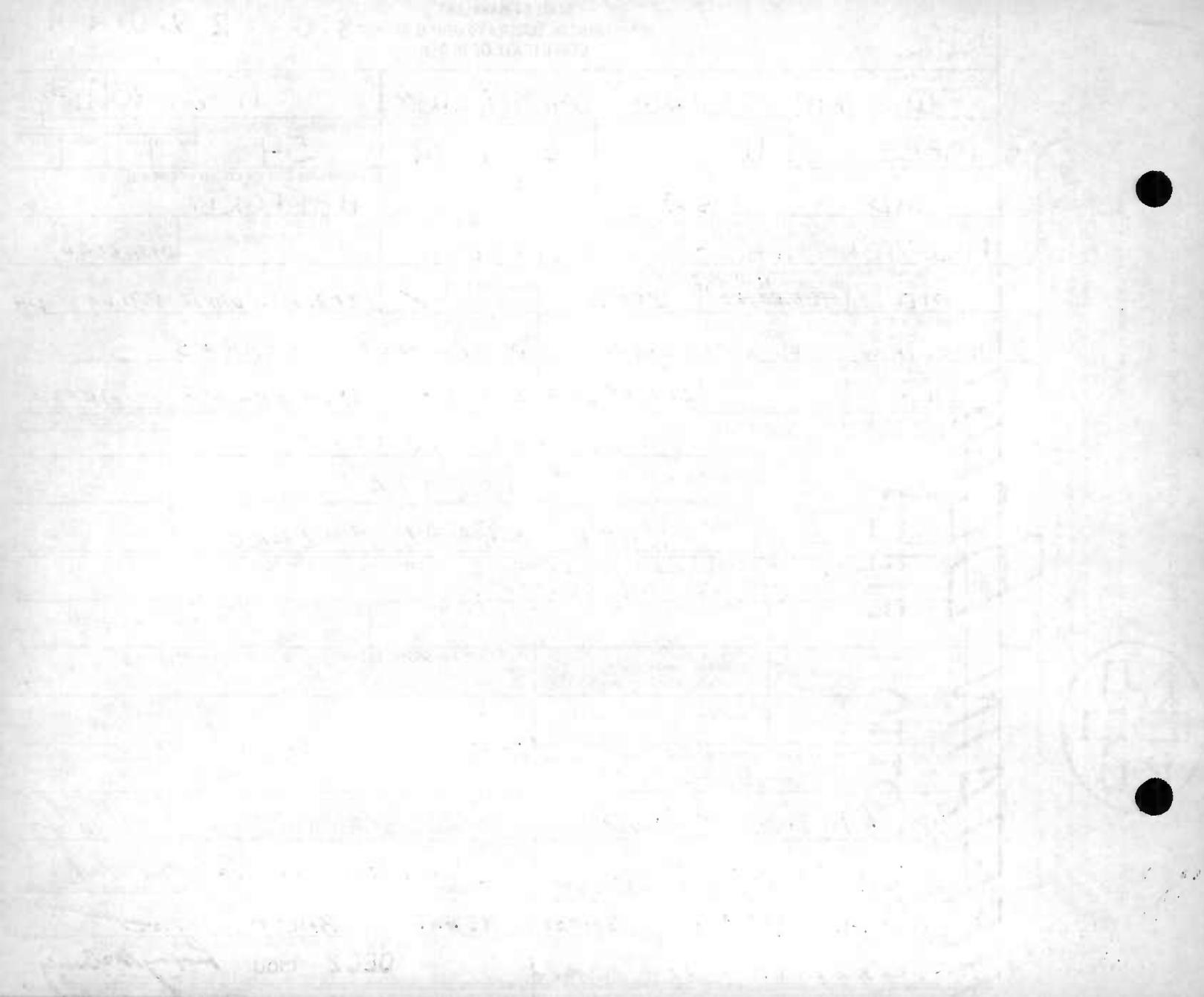
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of any death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 29044				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
WILLIAM			GEORGE	WINTERLING		11	27	80	11	25	P.M.					
3. SEX			4. RACE		5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)					
MALE			W		8	1	26				IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED			NEVER MARRIED	<input checked="" type="checkbox"/>	<input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
MD.			USA		MARRIED			WIDOWED	<input type="checkbox"/>	<input checked="" type="checkbox"/>	HARFORD					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
FALLSTON			FALLSTON GENERAL						DISABLED							
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
MD.			HARFORD		JOPPA						1302 WINDING VALLEY DR					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST					
WILLIAM			WINTERLING			MARGARET			KEARNS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
UNK			Z12 Z0 3876			ELIZABETH WINTERLING			ABOVE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL DEATH</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
5849 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>UREMIA</u>																
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ACUTE RENAL FAILURE</u>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>DIABETES MELLITUS</u>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>11-8-60</u> , 19 <u>60</u> , to <u>11-27-60</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11-27-60</u> , 19 <u>60</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																
22b. SIGNATURE <u>Dante N. Monakil, MD</u>												DEGREE	ATTENDING PHYSICIAN	MEDICAL DIRECTOR	STAFF PHYSICIAN	22c. DATE SIGNED <u>11/28/60</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS													
DANTE N. MONAKIL, MD			Fallston Gen Hosp, Fallston, MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY					
BURIAL			12/2/80		SACRED HEART			BALTO.			MD					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
J. G. CONNELLY			300 MACE			DEC 2 1980			HARRY DeCRISTY							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be filed with the office of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 24 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

29045

1. DECEASED NAME (Type or print)				First Evelyn	Middle IRENE	Last Wood	2d. DATE OF DEATH Month 11 Day 18 Year 1980	2b. HOUR 102 1PM		
3. SEX <b>Female</b>		4. RACE <b>Cau.</b>	S. DATE OF BIRTH <b>3-22-03</b>	6. AGE (in years lost, birthday) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7b. BIRTHPLACE (State or foreign country) <b>England</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Harford</b>						
10. CITY OR TOWN OF DEATH <b>Fallston</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>FALLSTON GENERAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13c. CITY OR TOWN <b>Harford Jarrettsville</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <b>2026 Schuster Road</b>						
14. FATHER'S NAME First Arthur Middle R. Lost Butterworth		15. MOTHER'S MAIDEN NAME First Lucy Middle Ann Lost Smith								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>162-36-6861</b>	17. INFORMANT <b>Irene E. Stewart</b>			Address <b>Jarrettsville, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		4149 Cardiac Arrest				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic Heart Disease								
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>79</b> , to <b>19</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>19</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> (did not) view the body after death.										
22b. SIGNATURE <i>Joseph Reinhard</i>		22c. DEGREE ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/22/1980</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Hillside Cemetery</b>	23d. LOCATION (City or Town) <b>Roslyn, Montgomery, Pa.</b>		(County)		(State)		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D. BY REGISTRAR <b>NOV 24 1980</b>	25b. REGISTRAR'S SIGNATURE <i>Creedy</i>		DATE			
M. G. Kurtz III		Jarrettsville, Md.								

